CHAPTER 7
SECTION 16.3

CHEMOTHERAPY ADMINISTRATION

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I. CPT[1] PROCEDURE CODES

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II. DESCRIPTION

Chemotherapy administration applies to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided in treatment of noncancerous diagnoses (e.g., cycphosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers.

III. POLICY

A. Chemotherapy administration, subcutaneous or intramuscular; non-hormonal and anti-neoplastic is covered.

B. Chemotherapy administration, intralesional, up to and including seven lesions, more than seven lesions, intravenous push technique, single, initial substance/drug, each additional substance/drug is covered.

C. Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug; each additional hour, initiation of prolonged chemotherapy infusion (more than eight hours requiring use of a portable or implantable pump and each additional sequential infusion (different substance/drug) up to one hour) is covered.

D. Chemotherapy administration, intra-arterial; push technique/infusion technique, up to one hour; infusion technique, each additional hour up to eight hours infusion technique (more than eight hours) requiring the use of a portable or implantable pump is covered.

E. Chemotherapy administration into pleural cavity, requiring and including thoracentesis; into the peritoneal cavity requiring and including peritoneocentesis is covered.

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F. Chemotherapy administration into CNS (e.g., intrathecal requiring and including spinal puncture) is covered.

G. Refilling and maintenance of portable pump is covered. Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous-intera arterial) is covered.

H. Irrigation of implanted venous access device for drug delivery systems is covered.

I. Chemotherapy injection, subarachnid or intraventricular via subcutaneous reservoir, single or multiple agents is covered.

J. Paclitaxel (Taxol) is covered for the treatment of breast cancer for the following indications (Healthcare Common Procedure Coding System (HCPCS) code J9265). This is not all inclusive. Other U.S. Food and Drug Administration (FDA)-approved labeled indications of Taxol are also covered):

1. Adjuvant therapy for node-positive breast cancer when administered sequentially following standard Doxorubicin-containing combination chemotherapy.

2. Adjuvant therapy for early-stage breast cancer.

3. First-line therapy for metastatic breast cancer.

a. Paclitaxel alone or in combination with Anthracycline (Doxorubicin, Epirubicin) for Anthracycline-naive patients.

b. Paclitaxel for Anthracyline-resistant patients.

c. Paclitaxel and Gemcitabine following failure of adjuvant chemotherapy.

d. Paclitaxel and Trastuzumab (Herceptin®) for HER-2-positive breast cancer.

e. Paclitaxel and Bevacizumab (Avastin™) for HER-2-negative breast cancer.

f. Paclitaxel and Carboplatin for HER-2-positive breast cancer.

4. Second-line therapy for advanced breast cancer for the treatment of breast cancer in patients who have metastatic disease refractory to conventional combination chemotherapy or who have experienced relapse within six months of adjuvant chemotherapy; prior therapy should have included an Anthracycline agent unless clinically contraindicated.

K. Paclitaxel protein-bound particles (Abraxane) (HCPCS code J9264) is covered for the treatment of breast cancer after failure of combination chemotherapy for metastatic breast cancer or relapse within six months of adjuvant chemotherapy. (This is not all inclusive. Other FDA-approved labeled indications are also covered.)

IV. EFFECTIVE DATES

A. October 25, 1999 for Paclitaxel (Taxol).

B. January 7, 2005, for Paclitaxel protein-bound particles (Abraxane).

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