

**Policy terminated because Medicaid covers codes in the same manner as
Health Choice.**

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1.0 Description of the Procedure, Product, or Service

Chemotherapy is a cancer treatment that uses chemical agents to kill cancer cells. The chemicals have a specific toxic effect upon cancer cells. They either destroy them or prevent the malignant cells from multiplying. The chemotherapy drugs may also have the same effect on normal cells. Administration of the drugs requires close monitoring for toxicity levels and for the recipient's response to therapy. Chemotherapy may be used in the following ways:

- a. As a first line therapy for advanced malignant disease;
- b. As an adjunct to local treatment, i.e., following surgery to remove the malignancy;
- c. As a primary treatment for localized malignant disease; or
- d. For direct instillation to the site affected by the malignant disease.

Please note that for the purpose of the NC Health Choice Program medical policy, the Food and Drug Administration's (FDA) approval means full, unrestricted market approval. Off-labeled indications (using a drug for a purpose other than what the FDA approved it for) may also be covered.

1.1 Medical Term Definitions

Adjunct: a supplement to the primary treatment.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Chemotherapy is covered when **BOTH** of the following criteria are met:

- a. The drug must be approved by the FDA; **AND**
- b. The drug must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
 1. The National Comprehensive Cancer Network Drugs & Biologics Compendium,
 2. The Thomson Micromedex DrugDex,
 3. The Elsevier Gold Standard's Clinical Pharmacology, or
 4. Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Note: Once a particular chemotherapeutic drug has received full and unrestricted FDA market approval, the Program will provide benefits for additional indications ("off label use") when an additional indication is recognized by any one of the reference compendia listed above and has shown to be effective and accepted for treatment of the cancer for which it has been prescribed.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Chemotherapy is not covered when:

- a. the appropriate FDA approval has not been granted (Refer to **Section 1.0**);
- b. the chemotherapeutic drug is not listed in one of the above medical reference sources;
- c. the chemotherapeutic drug has not proven to be an effective or accepted treatment for the diagnosis for which administration of the chemotherapeutic drug is anticipated.

4.3 Policy Guidelines

Coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required for chemotherapy for malignant disease.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Codes				
96401	96402	96405	96406	96409
+96411	96413	+96415	96416	+96417
96420	96422	+96423	96425	96440
96445	96450	96542	96549	

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s)

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Office and Home

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.