Introduction

Embolization is procedure to block blood flow. When the material used to block the blood flow contains chemotherapy agents as well, it is a way to treat liver cancer in some situations. This treatment is usually known as TACE. In this procedure a catheter (a long, thin, hollow tube) is inserted in an artery near the groin. It’s threaded to the tumor’s blood supply. Chemotherapy and tiny particles are then sent directly into the tumor. The particles block off — embolize — the artery feeding the tumor, causing it to shrink. The chemotherapy works to kill the cancer cells. This treatment can be used in the liver because it has two sources of blood: the portal vein and the hepatic artery. The portal vein supplies most of the blood to the liver. The hepatic artery supplies a lesser amount, and tumors that grow in the liver usually get their blood supply from the hepatic artery. As a result, TACE can be used to starve the blood supply of the tumor usually without affecting the blood supply to the rest of the liver. This policy describes when TACE may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
### Policy Coverage Criteria

#### Treatment | Medical Necessity
---|---
Transcatheter hepatic arterial chemoembolization | **Transcatheter hepatic arterial chemoembolization** may be considered **medically necessary for the following situations:**
- Hepatocellular cancer that is unresectable but confined to the liver and not associated with portal vein thrombosis
- As a bridge to transplant in patients with hepatocellular cancer where the intent is to prevent further tumor growth and to maintain a patient’s candidacy for liver transplant, and the following is true:
  - A single tumor less than 5 cm or no more than 3 tumors each less than 3 cm in size
  - Absence of extrahepatic disease or vascular invasion
  - Child-Pugh score of either A or B
- Treat liver metastasis in patients with metastatic neuroendocrine tumor with both of the following:
  - Whose symptoms persist despite systemic therapy
  - Who are not candidates for surgical resection
- To treat liver metastasis in patients with liver-dominant metastatic uveal melanoma

#### Treatment | Investigational
---|---
Transcatheter hepatic arterial chemoembolization | **Transcatheter hepatic arterial chemoembolization** is considered **investigational in all of the following situations:**
- As neoadjuvant or adjuvant therapy in hepatocellular cancer that is considered resectable
- To treat unresectable cholangiocarcinoma
- To treat liver metastases from any other tumors or to treat hepatocellular cancer that does not meet the criteria noted above, including recurrent hepatocellular carcinoma
- To treat hepatocellular tumors prior to liver transplantation except as noted above
## Evidence Review

### Background

**Transcatheter Arterial Chemoembolization**

Transcatheter arterial chemoembolization (TACE) is a minimally invasive procedure performed by interventional radiologists who inject highly concentrated doses of chemotherapeutic agents into the tumor tissues and to restrict tumor blood supply. The embolic agent(s) causes ischemia and necrosis of the tumor, and slows anticancer drug washout. The most common anticancer drugs used in published TACE studies for hepatocellular carcinoma (HCC) include doxorubicin (36%), followed by cisplatin (31%), epirubicin (12%), mitoxantrone (8%), and mitomycin C (8%).

The TACE procedure requires hospitalization for placement of a hepatic artery catheter and workup to establish eligibility for chemoembolization. Before the procedure, the patency of the portal vein must be demonstrated to ensure an adequate posttreatment hepatic blood supply.
With the patient under local anesthesia and mild sedation, a superselective catheter is inserted via the femoral artery and threaded into the hepatic artery. Angiography is then performed to delineate the hepatic vasculature, followed by injection of the embolic chemotherapy mixture. Embolic material varies but may include a viscous collagen agent, polyvinyl alcohol particles, or ethiodized oil. Typically, only 1 lobe of the liver is treated during a single session, with subsequent embolization procedures scheduled 5 days to 6 weeks later. In addition, because the embolized vessel recanalizes, chemoembolization can be repeated as many times as necessary.

**Hepatocellular Carcinoma**

Transcatheter arterial chemoembolization (TACE) of the liver has been associated with potentially life-threatening toxicities and complications, including severe postembolization syndrome, hepatic insufficiency, abscess, or infarction. TACE has been investigated to treat resectable, unresectable, and recurrent hepatocellular carcinoma (HCC), cholangiocarcinoma, liver metastases, and in the liver transplant setting. Treatment alternatives include resection when possible, chemotherapy administered systemically or by hepatic artery infusion (HAI). HAI involves continuous infusion of chemotherapy with an implanted pump, while TACE is administered episodically. HAI does not involve the use of embolic material.

**Intrahepatic Cholangiocarcinoma**

Intrahepatic cholangiocarcinoma (ICC) is the second most common primary liver malignancy after HCC (10% vs 90%, respectively). Surgical resection represents the only form of curative therapy, however, most ICC patients are not surgical candidates due to their advanced disease at diagnosis, which is caused by the lack of symptoms until late in the disease. The overall prognosis of ICC is far worse than for extrahepatic cholangiocarcinoma because of its late presentation. Most patients with ICC qualify for palliative therapy, including systemic chemotherapy and radiotherapy. However, such palliative options afford little to no survival improvement over supportive therapy alone, because ICC responds poorly to such existing therapies. Survival prognosis for patients with unresectable ICC is 5 to 8 months.

TACE has been explored in various settings: as a technique to prevent tumor progression in patients on the liver transplant waiting list, to downstage tumors so a patient may be considered a better candidate for liver transplantation, and to decrease the incidence of posttransplant recurrence in patients with larger (T3) tumors. All uses are in part related to the United Network
for Organ Sharing (UNOS) liver allocation policy, which prioritizes patients for receiving donor livers. The UNOS policy and the previous 3 uses are discussed further in the following sections.

**Neuroendocrine Tumors**

Neuroendocrine tumors are a heterogeneous group of typically slow-growing tumors with an indolent course, with the capacity to synthesize and secrete hormones. Liver metastases may result in significant hormonal symptoms and are associated with a poor prognosis. Systemic chemotherapy for these tumors has shown modest response rates of limited duration, and, although somatostatin analogues are usually effective at controlling symptoms, the disease eventually becomes refractory. Therefore, liver-directed therapies aim to reduce tumor burden, to lower hormone levels, and to palliate symptoms in patients with unresectable neuroendocrine metastases.

**Uveal Melanoma**

Uveal melanoma (also called ocular melanoma) is the most common primary ocular malignancy in adults and shows a strong predilection for liver metastases. Even with successful treatment of the primary tumor, up to 50% of patients will subsequently develop systemic metastases, with liver involvement in up to 90% of these patients. Metastatic uveal melanoma is resistant to systemic chemotherapy, leading to the evaluation of locoregional treatment modalities to control tumor progression in the liver, including TACE.

**UNOS Liver Allocation Policy**

In 2002, UNOS introduced the Model for End-Stage Liver Disease (MELD) system for allocating new livers to adult patients awaiting transplant. The MELD score is a continuous disease severity scale incorporating bilirubin, prothrombin time (ie, international normalized ratio [INR]), and creatinine into an equation, producing a number that ranges from 6 (less ill) to 40 (gravely ill). Aside from those in fulminant liver failure, donor livers are prioritized to those with the highest MELD number. This system accurately predicts the risk of dying from liver disease except for those with HCC, who often have low MELD scores, because bilirubin, INR, and creatinine levels are near normal. Therefore, patients with HCC are assigned additional allocation points according to the size and number (T stage) of tumor nodules as follows:
T1: 1 nodule greater than 1 cm and 1.9 cm or smaller

T2: 1 nodule between 2.0 and 5.0 cm, or 2 or 3 nodules each 1 cm or greater and up to 3.0 cm

T3: 1 nodule larger than 5.0 cm, or 2 or 3 nodules with at least 1 larger than 3.0 cm.

Patients with T1 lesions are considered at low risk of death on the waiting list, while those with T3 lesions are at high risk of posttransplant recurrence and are generally not considered transplant candidates. Patients with T2 tumors have an increased risk of dying while on the waiting list compared to those with T1 lesions, and are an acceptable risk of posttransplant tumor recurrence. Therefore, UNOS criteria, which were updated in 2013, prioritize only T2 HCC patients who meet specified staging and imaging criteria by allocating additional points equivalent to a MELD score predicting a 15% probability of death within 3 months. This definition of T2 lesions is often referred to as the Milan criteria, in reference to a key 1996 study that examined the recurrence rate of HCC according to the size of the initial tumor. Liver transplantation for those with T3 HCC is not prohibited, but these patients do not receive any priority on the waiting list. All patients with HCC awaiting transplantation are reassessed at 3-month intervals. Those whose tumors have progressed and are no longer T2 tumors lose the additional allocation points.

Additionally, nodules identified through imaging of cirrhotic livers are given an OPTN (Organ Procurement and Transplantation Network) class 5 designation. Class 5B and 5T nodules are eligible for automatic priority. Class 5B criteria consist of a single nodule 2 cm or larger and up to 5 cm (T2 stage) that meets specified imaging criteria. Class 5T nodules have undergone subsequent locoregional treatment after being automatically approved on initial application or extension. A single class 5A nodule (>1 cm and <2 cm) corresponds to T1 HCC and does not qualify for automatic priority. However, combinations of class 5A nodules are eligible for automatic priority if they meet stage T2 criteria. Class 5X lesions are outside of stage T2 and are not eligible for automatic exception points. Nodules less than 1 cm are considered indeterminate and are not considered for additional priority.

The UNOS allocation system provides strong incentives to use locoregional therapies to downsize tumors to T2 status and to prevent progression while on the waiting list. A 2010 report of a national conference in the United States addressed the need to better characterize the long-term outcomes of liver transplantation for patients with HCC and to assess justification for continuing the policy of assigning increased priority for candidates with early-stage HCC on the U.S. transplant waiting list. There was a general consensus for developing a calculated continuous HCC priority score for ranking HCC candidates on the list that would incorporate the calculated MELD score, α-fetoprotein, tumor size, and rate of tumor growth and that only
candidates with at least stage T2 tumors would receive additional HCC priority points. The report addressed the role of locoregional therapy to downstage patients from T3 to T2 and stated that the results of downstaging before liver transplantation are heterogeneous, with no upper limits for tumor size and number before downstaging across studies, and the use of different end points for downstaging before transplantation.

Summary of Evidence

**TACE for Unresectable Hepatocellular Carcinoma**

For individuals who have unresectable hepatocellular carcinoma (HCC) confined to the liver and not associated with portal vein thrombosis who receive transcatheter arterial chemoembolization (TACE), the evidence includes several randomized controlled trials (RCTs), large observational studies, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Studies of TACE have shown improved overall survival compared with only supportive care. One systematic review highlighted some of the possible biases associated with these studies. The evidence is sufficient to determine quantitatively that the technology results in a meaningful improvement in the net health outcome.

**TACE for Resectable HCC as Neoadjuvant or Adjuvant Therapy**

For individuals who have resectable HCC who receive neoadjuvant or adjuvant TACE, the evidence includes several RCTs and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Studies have shown little to no difference in overall survival rates with neoadjuvant or adjuvant TACE compared with surgery alone. A meta-analysis found no significant improvements in survival or recurrence with preoperative TACE for resectable HCC. While both RCTs and the meta-analysis that evaluated TACE as adjuvant therapy to hepatic resection in HCC reported positive results, the quality of individual studies and the methodologic issues related to the meta-analysis preclude certainty when interpreting the results. Well-conducted multicentric trials from United States or Europe representing relevant populations with adequate randomization procedures, blinded assessments, centralized oversight and publication in peer-reviewed journals are required. The evidence is insufficient to determine the effects of the technology on health outcomes.
**TACE Plus Radiofrequency Ablation for Resectable HCC**

For individuals who have resectable hepatocellular cancer who receive TACE plus radiofrequency ablation (RFA), the evidence includes a single RCT. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. The RCT failed to show the superiority in survival benefit with combination TACE plus RFA treatment compared to surgery for HCC lesions 3.0 cm or smaller. Further, an ad hoc subgroup analysis showed a significant benefit for surgery in recurrence and overall survival in patients with lesions larger than 3 cm. It cannot be determined from this trial whether TACE plus RFA is as effective as surgical resection for these small tumors. The evidence is insufficient to determine the effects of the technology on health outcomes.

**TACE Plus RFA for Unresectable HCC**

For individuals who have unresectable HCC who receive TACE plus RFA, the evidence includes multiple systematic reviews and RCTs. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Multiple meta-analyses and RCTs have shown a consistent benefit in survival or recurrence-free survival in favor of combination TACE plus RFA over RFA alone. However, results of these meta-analyses are difficult to interpret because the pooled data included heterogeneous patient populations and, in a few cases, included data from a study retracted due to questions about data veracity of. A larger well-conducted RCT has reported relative reduction in the hazard of death by 44% and a 14% difference in 4-year survival in favor of combination therapy. The major limitations of this trial were its lack of a TACE-alone arm and the generalizability of its findings to patient populations that have unmet need such as those with multiple lesions larger than 3 cm and Child-Pugh class B or C. Further, this single-center trial was conducted in China, and until these results have been reproduced in patient populations representative of pathophysiology and clinical stage more commonly found in the United States or Europe, the results may not be generalizable. The evidence is insufficient to determine the effects of the technology on health outcomes.

**TACE as a Bridge to Liver Transplant**

For individuals who have a single hepatocellular tumor less than 5 cm or no more than 3 tumors each less than 3 cm in size, absence of extrahepatic disease or vascular invasion, and Child-Pugh
class A or B seeking to prevent further tumor growth and to maintain patient candidacy for liver transplant who receive pretransplant TACE, the evidence includes multiple small prospective studies. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of comparative trials on various locoregional treatments as a bridge therapy to liver transplantation. Multiple small prospective studies have demonstrated that TACE can prevent dropouts from the transplant list. TACE has become an accepted method to prevent tumor growth and progression while patients are on the liver transplant waiting list. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**TACE for Unresectable Cholangiocarcinoma**

For individuals who have unresectable cholangiocarcinoma who receive TACE, the evidence includes several retrospective observational studies and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. RCT evaluating the benefit of adding TACE to standard of care for patients with unresectable cholangiocarcinoma are lacking. Results of 3 retrospective studies have shown a survival benefit with TACE over standard of care. These studies lacked matched patient controls. Although the observational data are consistent, the lack of randomization limits definitive conclusions. The evidence is insufficient to determine the effects of the technology on health outcomes.

**TACE for Symptomatic Unresectable Neuroendocrine Tumors**

For individuals who have symptomatic metastatic neuroendocrine tumor despite systemic therapy who are not candidates for surgical resection who receive TACE, the evidence includes retrospective single-cohort studies. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence from RCTs supporting use of TACE. Uncontrolled trials have reported that TACE reduces symptoms and tumor burden, and improves hormone profiles. Generally, the response rates are over 50% including patients with massive hepatic tumor burden. While many studies have demonstrated symptom control, survival benefits are less clear. Despite the uncertain benefit on survival, the use of transcatheter arterial chemoembolization to palliate the symptoms associated with hepatic neuroendocrine metastases can provide a clinically meaningful improvement in net health outcome. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
TACE for Liver-Dominant Metastatic Uveal Melanoma

For individuals who have liver-dominant metastatic uveal melanoma who receive TACE, the evidence includes observational studies and reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence from RCTs assessing use of TACE. Noncomparative prospective and retrospective studies have reported improvement in tumor response and survival compared with historical controls. Given the very limited treatment response from systemic therapy and the rarity of this condition, the existing evidence may support conclusions that TACE meaningfully improves outcomes for patients with hepatic metastases from uveal melanoma. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

TACE for Other Unresectable Hepatic Metastases

For individuals who have unresectable hepatic metastases from any other types of primary tumor (eg, colorectal or breast cancer) who receive TACE, the evidence includes multiple RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, disease-specific survival, quality of life, and treatment-related mortality and morbidity. Multiple RCTs and numerous nonrandomized studies have compared TACE with alternatives in patients who have colorectal cancer with metastases to the liver. Nonrandomized studies report that TACE can stabilize disease in 40% to 60% of treated patients but whether this translates into prolonged survival benefit relative to systemic chemotherapy alone is uncertain. Two small RCTs have reported that TACE with drug-eluting beads has resulted in statistically significant improvements in response rate and progression-free survival. Whether this translates into a prolonged survival benefit relative to systemic chemotherapy alone is uncertain. For cancers other than colorectal, the evidence is extremely limited and no conclusions can be made. Studies have small numbers of patients and the results have varied due to differences in patient selection criteria and treatment regimens used. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.
### Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>NCT01906216</td>
<td>Sorafenib With or Without Transarterial Chemoembolization (TACE) in Advanced Hepatocellular Carcinoma: A Multicenter, Randomized, Controlled Trial</td>
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<td>June 2016 (ongoing)</td>
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<td>NCT01676194</td>
<td>Efficacy of Transarterial Chemoembolization With DC-BeadsR Prior to Liver Transplantation for Hepatocellular Carcinoma on Patient Survival: A Prospective Multicentre and Randomized Study</td>
<td>140</td>
<td>Aug 2017</td>
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<tr>
<td>NCT01869088</td>
<td>Phase III Trial of Transcatheter Arterial Chemoembolization (TACE) Plus Recombinant Human Adenovirus Type 5 Injection for Unresectable Hepatocellular Carcinoma (HCC)</td>
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<td>Jan 2018</td>
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<tr>
<td>NCT00908752a</td>
<td>A Randomized, Double-blind, Multicenter Phase III Study of Brivanib Versus Placebo as Adjuvant Therapy to Transarterial Chemo-Embolization (TACE) in Patients With Unresectable Hepatocellular Carcinoma (The BRISK TA Study)</td>
<td>734</td>
<td>Jan 2018</td>
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<tr>
<td>NCT01512407</td>
<td>Randomised Controlled Trial on Adjuvant Transarterial Chemoembolisation After Curative Hepatectomy for Hepatocellular Carcinoma</td>
<td>144</td>
<td>Jan 2018</td>
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<tr>
<td>NCT01004978</td>
<td>A Phase III Randomized, Double-Blind Trial of Chemoembolization With or Without Sorafenib in Unresectable Hepatocellular Carcinoma (HCC) in Patients With and Without Vascular Invasion</td>
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<td>Feb 2018</td>
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<tr>
<td>NCT02936388</td>
<td>Transarterial Radioembolisation in Comparison to Transarterial Chemoembolisation in Uveal Melanoma Liver Metastasis (SirTAC)</td>
<td>108</td>
<td>Dec 2018</td>
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<tr>
<td>NCT01833286</td>
<td>Radiofrequency Ablation Combined With Transcatheter Arterial Chemoembolization Versus Re-resection for Recurrent Hepatocellular Carcinoma</td>
<td>200</td>
<td>Jul 2019</td>
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</table>

NCT: national clinical trial.

a Denotes industry-sponsored or cosponsored trial.
Clinical Input Received from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 1 specialty medical society (2 reviewers) and 3 academic medical centers while this policy was under review in 2012. There was general agreement among reviewers that use of TACE was medically necessary for indications in the policy; however, they were split for the use as a bridge to transplant. There was general support for the investigational policy statement for the use of TACE as neoadjuvant or adjuvant therapy in resectable HCC. Reviewers were split over the investigational policy statement to treat other liver metastases or for recurrent HCC. Four reviewers provided input on the use of TACE in unresectable cholangiocarcinoma; 2 consider it investigational and 2 consider it investigational but also medically necessary, the latter citing data showing a survival benefit of TACE compared with supportive therapy.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network Guidelines

Hepatocellular Carcinoma

National Comprehensive Cancer Network (NCCN) guidelines on hepatocellular carcinoma (v.2.2017) list transarterial chemoembolization as an option for patients not candidates for surgically curative treatments or as a part of strategy to bridge patients for other curative therapies (category 2A).\textsuperscript{70} The guidelines also recommend that patients with tumors size between 3 and 5 cm can be considered for combination therapy with ablation and arterial embolization and those with unresectable or inoperable tumors greater than 5 cm be treated using arterial embolic approaches or systemic therapies. Additionally, transcatheter arterial chemoembolization is relatively contraindicated in patients with portal vein thrombosis and bilirubin levels greater than 3 mg/dL, and is absolutely contraindicated with Child-Pugh class C liver function.
**Intrahepatic Cholangiocarcinoma**

NCCN guidelines on intrahepatic cholangiocarcinoma (v.2.2017) do not address the use of TACE in intrahepatic cholangiocarcinoma.\(^{54}\)

**Neuroendocrine Tumors, Carcinoid, and Islet Cell Tumors**

NCCN guidelines on neuroendocrine tumors, carcinoid, and islet cell tumors (v.3.2017) recommend chemoembolization for patients with unresectable liver metastases (category 2B).\(^{55}\)

**Uveal Cancer**

No NCCN guidelines were identified for uveal malignancies.

**Colon Cancer**

NCCN guidelines on colon cancer (v.2.2017) recommend the use of arterially directed embolic therapy for metastatic colon cancer to the liver (category 3 recommendation; based on any level of evidence. There is major disagreement among NCCN panelists about whether the intervention is appropriate.\(^{56}\)

**Breast Cancer**

NCCN guidelines on breast cancer (v.2.2016) do not address TACE as a treatment option for breast cancer metastatic to the liver.\(^{57}\)

**Medicare National Coverage**

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.
Regulatory Status

Chemoembolization for hepatic tumors is a medical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration. However, the embolizing agents and drugs are subject to Food and Drug Administration approval.

References


History

<table>
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<th>Date</th>
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</tr>
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<td>Cross Reference Update - No other changes.</td>
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<td>Replace Policy - Policy updated with literature search. Policy statement updated to include &quot;hepatocellular carcinoma or unresectable hepatocellular carcinoma (HCC) in patients who may be waiting for a liver transplant&quot; as a medically necessary indication. References and cross reference added. Reviewed and recommended by the Oncology Advisory Panel on February 21, 2008.</td>
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<td>08/10/10</td>
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<td>02/27/12</td>
<td>Related policies updated; 7.01.133 added.</td>
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<td>Replace policy. Policy updated with extensive reorganization to the Rationale and References sections; Description and Policy Guidelines also updated. Policy statements expanded to outline medical necessity coverage for treatment of hepatocellular cancer that is unresectable but confined to the liver and not associated with portal vein thrombosis; as a bridge to transplant for patients with hepatocellular cancer with the intention of preventing further tumor growth and maintaining patient's candidacy for liver transplant; to treat liver metastasis in symptomatic patients with metastatic neuroendocrine tumor with persisting symptoms despite systemic therapy who are not candidates for surgical resection; and to treat liver metastasis in patients with liver-dominant metastatic uveal melanoma. Two new investigational policy statements have been added, one addressing treatment of liver metastases for any other tumors, the other addressing the treatment of unresectable cholangiocarcinoma. Reviewed by OAP on February 16, 2012.</td>
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<td>Coding Update. CPT code 37204 discontinued effective 12/31/13.</td>
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<td>05/05/14</td>
<td>Annual Review. Policy updated with literature search. References 7,8,10,13,44,47 added, No change to policy statements. Coding update: deleted code 37204 replaced with 37243 (added to policy); HCPCS code Q0083 removed – not specific to policy. ICD-9 code 9925 removed, as it is not applicable; ICD-9 and ICD-10 diagnosis codes remove – these are not utilized in adjudication of policy.</td>
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<td>Annual Review, approved September 5, 2017. References updated through June 12, 2017; references 11, 12, 29-42, 46, 63, and 65 were added. No changes made to the intent of the policy statements, minor addition was made to treat hepatocellular</td>
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cancer that is unresectable but confined to the liver and not associated with portal vein thrombosis and liver function not characterized as Child-Pugh class C.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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Premera:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5992. TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action if you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5992. TTY 800-842-5357
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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

中文 (Chinese): 本通知有重要的讯息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保單的重要訊息。本通知可能有重要的日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請接電話 800-722-1471 (TTY: 800-842-5357)。

