Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Hyperthermic Intraperitoneal Chemotherapy (HIPEC)

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☒ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care-- A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Hyperthermic Intraperitoneal Chemotherapy (HIPEC) is used at time of surgery as a treatment option for some cancers that have metastasized within the peritoneal cavity. HIPEC is delivered into the peritoneal space following cytoreductive surgical (CRS) procedure. The goal of CRS is complete cytoreduction (removal of all evidence of macroscopic disease), but if unable to achieve complete CRS, surgical goal should be optimal CRS, defined as no greater than 1 cm residual disease for ovarian, primary peritoneal, and fallopian tube cancer and no greater than 2.5 mm for other forms of malignancy.

The goal of HIPEC is to enhance the cytotoxic effect of chemotherapeutic drugs, thereby eliminating micrometastases and disseminated tumor cells remaining in the peritoneal space. The chemotherapeutic agents employed in HIPEC need to have a cell cycle nonspecific mechanism of action and should ideally show a heat-synergistic cytotoxic effect. Specific technical training and a solid knowledge of regional chemotherapy management are required. Treatment-related toxicity is a risk and should be considered during patient selection process.

Clinical Guideline Coverage Criteria

PRIOR AUTHORIZATION IS NOT REQUIRED: Providers will not routinely be required to submit documentation to Tufts Health Plan prior to providing services. However, documentation may be requested at any time to confirm that the services provided meet current standards referenced below: The Plan covers Hyperthermic Intraperitoneal Chemotherapy (HIPEC) when used with cytoreductive surgery for the following:

1. Pseudomyxoma peritonei (PMP)

2. Diffuse malignant peritoneal mesothelioma
3. Peritoneal carcinomatosis resulting from appendiceal, colon, rectal or ovarian cancer with limited peritoneal-only metastases.

Limitations

The Plan considers cytoreductive surgery and perioperative intraperitoneal chemotherapy for all other indications unproven and investigational.

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed, first 60 minutes (list separately in addition to code for primary procedure)
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (list separately in addition to code for primary procedure)
96549	Unlisted chemotherapy procedure

Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (list separately in addition to code for primary procedure)

References:

1. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination 110.1: Hyperthermia for Treatment of Cancer. Medicare Coverage Database. Accessed November 30, 2021.
2. Chua TC, Moran BJ, Sugarbaker PH, et al. Early- and long-term outcome data of patients with pseudomyxoma peritonei from appendiceal origin treated by a strategy of cytoreductive surgery and hyperthermic intraperitoneal chemotherapy. .J Clin Oncol. 2012 Jul 10;30(20):2449-56.
3. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology. Colon Cancer. (Version 4.2025). June 27, 2025. Accessed September 18, 2025. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf
4. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology. Gastric Cancer. (Version 3.2025). August 22, 2025. Accessed September 18, 2025. https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf
5. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology. Ovarian Cancer: Including Fallopian Tube Cancer and Primary Peritoneal Cancer. (Version 3. 2025). July 16, 2025. Accessed September 18, 2025. https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf
6. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology. Mesothelioma: Peritoneal. (Version 2.2025). January 14, 2025 Accessed September 18, 2025. https://www.nccn.org/professionals/physician_gls/pdf/meso_peritoneal.pdf
7. Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis Resulting from Peritoneal Mesothelioma. Hayesinc.com/login [via subscription only]. Published on November 5, 2019. Updated January 27, 2023. Accessed September 18, 2025.
8. Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis Resulting from Ovarian Cancer. Hayesinc.com/login [via subscription only]. Published August 26, 2019. Updated September 14, 2022. Accessed September 18, 2025.
9. Hyperthermic Intraperitoneal Chemotherapy for Sarcoma with Peritoneal Involvement. Hayesinc.com/login [via subscription only]. Published December 13, 2019. Updated March 7, 2023. Accessed September 18, 2025.
10. Ceelen W, Demuytere J, de Hingh I. Hyperthermic Intraperitoneal Chemotherapy: A Critical Review. Cancers (Basel). 2021;13(13):3114. Published 2021 Jun 22. doi:10.3390/cancers13133114
11. Repullo DJ, Barbois S, Leonard D, et al. The absence of benefit of perioperative chemotherapy in initially resectable peritoneal metastases of colorectal cancer origin treated with complete cytoreductive surgery and hyperthermic intraperitoneal chemotherapy: A retrospective analysis. Eur J Surg Oncol. 2021;47(7):1661-1667.

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13. Hoehn RS, Rieser CJ, Choudry MH, Melnitchouk N, Hechtman J, Bahary N. Current Management of Appendiceal Neoplasms. Am Soc Clin Oncol Educ Book. 2021;41:1-15. doi:10.1200/EDBK_321009
14. Elattar A, Bryant A, Winter-Roach BA, Hatem M, Naik R. Optimal primary surgical treatment for advanced epithelial ovarian cancer. Cochrane Database Syst Rev. 2011;2011(8):CD007565. Published 2011 Aug 10. doi:10.1002/14651858.CD007565.pub2
15. Van Driel WJ, Koole SN, Sikorska K, et al. Hyperthermic Intraperitoneal Chemotherapy in Ovarian Cancer. N Engl J Med. 2018;378:230-40.
16. Zambrano-Vera K, Sardi A, Munoz-Zuluaga C, et al. Outcomes in Peritoneal Carcinomatosis from Appendiceal Goblet Cell Carcinoma Treated with Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy (CRS/HIPEC). Ann Surg Oncol. 2020;27(1):179-187.
17. Glasgow SC, Gaertner W, Stewart D, et al. The American Society of Colon and Rectal Surgeons, Clinical Practice Guidelines for the Management of Appendiceal Neoplasms. Dis Colon Rectum 2019;62:1425–1438
18. Liu Y, et.al. Cytoreductive surgery under aminolevulinic acid-mediated photodynamic diagnosis plus hyperthermic intraperitoneal chemotherapy in patients with peritoneal carcinomatosis from ovarian cancer and primary peritoneal carcinoma: results of a phase I trial. Ann Surg Oncol. 2014 Dec;21(13):4256-62. doi: 10.1245/s10434-014-3901-5. Epub 2014 Jul 24. PMID: 25056850; PMCID: PMC4218977.
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20. Tonello M, et.al. National Guidelines for Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) in Peritoneal Malignancies: A Worldwide Systematic Review and Recommendations of Strength Analysis. Ann Surg Oncol. 2025 Aug;32(8):5795-5806. doi: 10.1245/s10434-025-17518-z. Epub 2025 May 24. PMID: 40413333; PMCID: PMC12222385.Acs M, et. al. Current clinical practices of cytoreductive surgery (CRS) and hyperthermic intraperitoneal chemotherapy (HIPEC). Innov Surg Sci. 2024 Mar 14;9(1):3-15. doi: 10.1515/iss-2023-0055. PMID: 38826635; PMCID: PMC11138857.
21. Taqi K, et. al. Long-Term Outcomes following Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis of Colorectal Origin. Curr Oncol. 2024 Jun 25;31(7):3657-3668. doi: 10.3390/curroncol31070269. PMID: 39057141; PMCID: PMC11275434.
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Approval And Revision History

October 21, 2020: Reviewed by the IMPAC; renewed without changes

Subsequent endorsement date(s) and changes made:

- November 4, 2020: Fax number for Unify updated
- October 20, 2021: Reviewed by IMPAC, renewed without changes
- February 16, 2022: Reviewed by Medical Policy Approval Committee (MPAC) for effective date February 22, 2022, removed gastric cancer as covered condition, removed prophylactic use of HIPEC, added appendiceal, colon and rectal cancer as covered conditions and removed criterion has medical condition which precludes major surgery
- March 16, 22: Freedom removed from template
- December 21, 2022: reviewed by MPAC, renewed without changes
- November 16, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and coding updated per AMA CPT® the following codes were added: 96547 and 96548 effective January 1, 2024
- December 1, 2023: Reviewed and approved by the UM Committee
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- December 13, 2024: Reviewed and approved by the UM Committee, effective January 1, 2025
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes, references updated, effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.