Policy Statement

Cytoreductive surgery plus hyperthermic intraperitoneal chemotherapy (HIPEC) at the time of surgery may be considered medically necessary for the treatment of either of the following:

- Pseudomyxoma peritonei
- Diffuse malignant peritoneal mesothelioma

The use of HIPEC may be considered medically necessary in newly diagnosed epithelial ovarian or fallopian tube cancer at the time of interval cytoreductive surgery when all of the following criteria are met:

- The patient has stage III disease (see Policy Guidelines section)
- The patient is not eligible for primary cytoreductive surgery or surgery had been performed but was incomplete and will receive neoadjuvant chemotherapy and subsequent interval debulking surgery (see Policy Guidelines section)
- It is expected that complete or optimal cytoreduction can be achieved at time of the interval debulking surgery (see Policy Guidelines section)

The use of HIPEC in all other settings to treat ovarian cancer, including but not limited to stage IIIC or IV ovarian cancer, is considered investigational.

Cytoreductive surgery plus HIPEC are considered investigational for all other indications, including but not limited to:

- Peritoneal carcinomatosis from colorectal cancer, gastric cancer, or endometrial cancer
- Goblet cell tumors of the appendix

Policy Guidelines

Ovarian cancer staging is as follows:

- Stage I: The cancer is confined to the ovary or fallopian tube.
- Stage II: The cancer involves one or both ovaries with pelvic extension.
- Stage III: The cancer has spread within the abdomen.
- Stage IV: The cancer is widely spread throughout the body.

Eligibility for neoadjuvant chemotherapy and interval debulking surgery is based on a high perioperative risk profile (i.e., the patient is a poor candidate to withstand an aggressive initial cytoreductive procedure) or a low likelihood of achieving cytoreduction to less than 1 cm (i.e., the patient has extensive disease that precludes upfront optimal cytoreduction) or surgery has been performed but was incomplete (i.e., after surgery, one or more residual tumors measuring greater than 1 cm in diameter were present).

Complete cytoreduction is defined as no visible disease and optimal cytoreduction as one or more residual tumors measuring 10 mm or less in diameter remaining.

Coding

The coding for this overall procedure would likely involve codes for the surgery, the intraperitoneal chemotherapy, and the hyperthermia.
Cytoreduction
There is no specific CPT code for the surgical component of this complex procedure. It is likely that a series of CPT codes would be used describing exploratory laparotomies of various components of the abdominal cavity, in addition to specific codes for resection of visceral organs, depending on the extent of the carcinomatosis.

Intraperitoneal Chemotherapy
CPT code 96446 identifies “chemotherapy administration into the peritoneal cavity via indwelling port or catheter.” When performed using a temporary catheter or performed intraoperatively, the unlisted code 96549 (unlisted chemotherapy procedure) would be reported.

Hyperthermia
This procedure does not refer to the external application of heat as described by CPT code 77605. There are no codes for the heating of the chemotherapy.

Description
Cytoreductive surgery (CRS) includes peritonectomy (i.e., peritoneal stripping) procedures and multivisceral resections, depending on the extent of intra-abdominal tumor dissemination. CRS may be followed intraoperatively by infusion of intraperitoneal chemotherapy with or without heating, which is intended to improve the tissue penetration of the chemotherapy. When heated, this is referred to as hyperthermic intraperitoneal chemotherapy (HIPEC). CRS and HIPEC have been proposed for a number of intra-abdominal and pelvic malignancies such as pseudomyxoma peritonei and peritoneal carcinomatosis from colorectal, gastric, or endometrial cancer.

Related Policies
- N/A

Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status
Mitomycin, carboplatin, and other drugs used for HIPEC have not been approved by the U.S. Food and Drug Administration (FDA) for this indication. Cyclophosphamide and nitrogen mustard are FDA-approved for intraperitoneal administration, but neither is used regularly for this purpose.

Several peritoneal lavage systems (FDA product code: LGZ) have been cleared for marketing by the FDA through the 510(k) process to provide “warmed, physiologically compatible sterile solution” (e.g., Performer® HT perfusion system; RanD Srl). None has received marketing approval
or clearance to administer chemotherapy. The FDA has issued warnings to manufacturers of devices that are FDA-cleared for peritoneal lavage using sterile saline solutions when these devices are marketed for off-label use in HIPEC (e.g., ThermoSolutions; Belmont Instrument).

### Rationale

#### Background

**Pseudomyxoma Peritonei**

Pseudomyxoma peritonei is a clinicopathologic disease characterized by the production of mucinous ascites and mostly originates from epithelial neoplasms of the appendix. Appendix cancer is diagnosed in fewer than 1000 Americans each year; less than half are epithelial neoplasms. As mucin-producing cells of the tumor proliferate, the narrow lumen of the appendix becomes obstructed and subsequently leads to appendiceal perforation. Neoplastic cells progressively colonize the peritoneal cavity and produce copious mucin, which collects in the peritoneal cavity. Pseudomyxoma peritonei ranges from benign (disseminated peritoneal adenomucinosis) to malignant (peritoneal mucinous carcinomatosis), with some intermediate pathologic grades. Clinically, this syndrome ranges from early pseudomyxoma peritonei, usually discovered during imaging or a laparotomy performed for another reason, to advanced cases with a distended abdomen, bowel obstruction, and starvation.

#### Treatment

The conventional treatment of pseudomyxoma peritonei is surgical debulking, repeated as necessary to alleviate pressure effects. However, repeated debulking surgeries become more difficult due to progressively thickened intra-abdominal adhesions, and this treatment is palliative, leaving visible or occult disease in the peritoneal cavity.

**Peritoneal Carcinomatosis of Colorectal Origin**

Peritoneal dissemination develops in 10% to 15% of patients with colon cancer. Treatment

Despite the use of increasingly effective regimens of chemotherapy and biologic agents to treat advanced disease, peritoneal metastases are associated with a median survival of 6 to 7 months.

**Peritoneal Carcinomatosis of Gastric Origin**

Peritoneal carcinomatosis is detected in more than 30% of patients with advanced gastric cancer and is a poor prognostic indicator. The median survival is 3 months, and 5-year survival is less than 1%. Sixty percent of deaths from gastric cancer are attributed to peritoneal carcinomatosis.

**Peritoneal Mesothelioma**

Malignant mesothelioma is a relatively uncommon malignancy that may arise from the mesothelial cells lining the pleura, peritoneum, pericardium, and tunica vaginalis testis. In the United States, 200 to 400 new cases of diffuse malignant peritoneal mesothelioma are registered every year, accounting for 10% to 30% of all-type mesothelioma. Diffuse malignant peritoneal mesothelioma has traditionally been considered a rapidly lethal malignancy with limited and ineffective therapeutic options. The disease is usually diagnosed at an advanced stage and is characterized by multiple variably sized nodules throughout the abdominal cavity. As the disease progresses, the nodules become confluent to form plaques, masses, or uniformly cover peritoneal surfaces. In most patients, death eventually results from locoregional progression within the abdominal cavity. In historical case series, treatment by palliative surgery, systemic or
intrapertitoneal chemotherapy, and abdominal irradiation has resulted in a median survival of 12 months.6

**Treatment**

Surgical cytoreduction (resection of visible disease) in conjunction with hyperthermic intraperitoneal chemotherapy (HIPEC) is designed to remove visible tumor deposits and residual microscopic disease. By delivering chemotherapy intraperitoneally, drug exposure to the peritoneal surface is increased some 20-fold compared with systemic exposure. In addition, previous animal and in vitro studies have suggested that the cytotoxicity of mitomycin C is enhanced at temperatures greater than 39°C (102.2°F).

**Ovarian Cancer**

Several different types of malignancies can arise in the ovaries; epithelial carcinoma is the most common, accounting for 90% of malignant ovarian tumors. Epithelial ovarian cancer is the fifth most common cause of cancer death in women in the United States. Most ovarian cancer patients (>70%) present with widespread disease, and annual mortality is 65% of the incidence rate.

**Treatment**

Current management of advanced epithelial ovarian cancer is cytoreductive surgery (CRS) followed by combination chemotherapy. Tumor recurrences are common, and the prognosis for recurrent disease is poor.

CRS plus HIPEC in combination with systemic chemotherapy is being studied for primary and recurrent disease. Because HIPEC is administered at the time of surgery, treatment-related morbidity may be reduced compared with intraperitoneal chemotherapy administered postoperatively.

**CRS plus HIPEC**

CRS includes peritonectomy (i.e., peritoneal stripping) procedures and multivisceral resections, depending on the extent of intra-abdominal tumor dissemination.7 CRS may be followed intraoperatively by the infusion of intraperitoneal chemotherapy, most commonly mitomycin C. The intraperitoneal chemotherapy may be heated, which is intended to improve the tissue penetration, and this is referred to as HIPEC. Inflow and outflow catheters are placed in the abdominal cavity, along with probes to monitor temperature. The skin is then temporarily closed during the chemotherapy perfusion, which typically runs for 1 to 2 hours.

CRS plus HIPEC is being evaluated for the following conditions:

- Pseudomyxoma peritonei;
- Peritoneal carcinomatosis of colorectal, gastric, or endometrial origin;
- Peritoneal mesothelioma;
- Ovarian cancer; and
- Appendiceal goblet cell tumors.

**Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the
intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

### Pseudomyxoma Peritonei

Discussion for this indication is divided into primary treatment and treatment for recurrence.

### Clinical Context and Therapy Purpose

The purpose of cytoreductive surgery (CRS) plus hyperthermic intraperitoneal chemotherapy (HIPEC) in patients who have pseudomyxoma peritonei is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of CRS plus HIPEC improve the net health outcome in patients with pseudomyxoma peritonei?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant population of interest are individuals with pseudomyxoma peritonei.

**Interventions**
The combination therapy being considered is CRS plus HIPEC.

**Comparators**
The following therapies are currently being used to treat pseudomyxoma peritonei: CRS alone and systemic chemotherapy.

**Outcomes**
The general outcomes of interest are progression-free survival (PFS), overall survival (OS), and postoperative morbidity.

Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

**Primary Treatment**

Table 1 summarizes the relevant studies on pseudomyxoma peritonei, some of which are discussed next.

Jimenez et al (2014) retrospectively reviewed a prospective database of patients with peritoneal carcinomatosis maintained by a U.S. medical center.11 Two hundred two patients with peritoneal carcinomatosis from appendiceal cancer who underwent CRS plus HIPEC were included; 125 (62%) patients had high-grade tumors (peritoneal mucinous carcinomatosis), and 77 (38%) patients had low-grade tumors (disseminated peritoneal adenomucinosis). Results for the entire cohort and for subgroups defined by tumor histology are shown in Table 1. In the high-grade peritoneal mucinous carcinomatosis group, Peritoneal Cancer Index (PCI) score (scale range, 0-39), completeness of cytoreduction, and lymph node status were significantly associated with survival; in the low-grade disseminated peritoneal adenomucinosis group, completeness of cytoreduction was significantly associated with survival.

Glehen et al (2010) published a retrospective, multicenter cohort study that evaluated toxicity and prognostic factors after CRS plus HIPEC and/or unheated intraperitoneal chemotherapy for
5 days postoperatively. Patients had diffuse peritoneal disease from malignancies of multiple different histologic origins. Exclusion criteria were perioperative chemotherapy performed more than seven days after surgery and the presence of extra-abdominal metastases. The study included 1290 patients from 25 institutions who underwent 1344 procedures between 1989 and 2007. HIPEC was performed in 1154 procedures. Postoperative mortality was 4.1%. The principal origin of peritoneal carcinomatosis was pseudomyxoma peritonei in 301 patients. Median OS for patients with pseudomyxoma peritonei was not reached (the median OS for all patients was 34 months.)

Additional information about the subgroup of patients with pseudomyxoma peritonei was provided by Elias et al (2010). CRS was conducted in 219 (73%) patients, and HIPEC was performed in 255 (85%). The primary tumor site was the appendix in 91% of patients, the ovary in 7% and unknown in 2%. Tumor histology was disseminated peritoneal adenomucinosis in 51%, peritoneal carcinomatosis with intermediate features in 27%, and peritoneal mucinous carcinomatosis in 22%. The postoperative mortality was 4% and the morbidity rate, 40%. Mean follow-up was 88 months. One-, 3-, and 5-year OS rates were 89.4%, 84.8%, and 72.6% respectively. The 10-year OS rate was 54.8%. Median OS had not yet been reached but would exceed 100 months. Disease-free survival (DFS) was 56% at 5 years (the median duration of DFS was 78 months). A multivariate analysis identified five prognostic factors: extent of peritoneal seeding (p=0.004), institution (p<0.001), pathologic grade (p=0.03), sex (p=0.02), and use of HIPEC (p=0.04). When only the 206 patients with complete CRS were considered, the extent of peritoneal seeding was the only significant prognostic factor (p=0.004).

Chua et al (2009) reported on the long-term survival of 106 patients with pseudomyxoma peritonei treated between 1997 and 2008 with CRS plus HIPEC and/or unheated intraperitoneal chemotherapy for 5 days postoperatively. Sixty-nine percent of patients had complete cytoreduction. Eighty-three (78%) patients had HIPEC intraoperatively, 81 (76%) patients had unheated postoperative intraperitoneal chemotherapy, and 67 (63%) patients had both. Seventy-three patients had disseminated peritoneal adenomucinosis, 11 had peritoneal mucinous carcinomatosis, and 22 had mixed tumors. The mortality rate was 3% and the severe morbidity rate was 49%. The median follow-up was 23 months (range, 0-140 months). The median OS was 104 months with a 5-year OS rate of 75%. Median PFS was 40 months with 1-, 3-, and 5-year PFS rates of 71%, 51% and 38% respectively. Factors influencing OS included the histopathologic type of tumor (p=0.002), with the best survival in patients with disseminated peritoneal adenomucinosis, and worst survival in patients with peritoneal mucinous carcinomatosis. Other factors influencing survival were the use of both HIPEC and unheated postoperative intraperitoneal chemotherapy, completeness of cytoreduction, and severe morbidity.

Vaira et al (2009) reported on a single institution’s experience managing pseudomyxoma peritonei with CRS and HIPEC in 60 patients, 53 of whom had final follow-up data. The postoperative morbidity rate was 45% no postoperative deaths were observed. The primary tumor was appendiceal adenocarcinoma in 72% of patients and appendiceal adenoma in 28%. Approximately half of the patients with adenocarcinoma had received previous systemic chemotherapy. Five- and 10-year OS rates were 94% and 85% respectively, 5- and 10-year DFS rates were 80% and 70% respectively. Significant differences in improved OS were observed in patients who had complete CRS (p<0.003) and in those with histologic type disseminated peritoneal adenomucinosis compared with those with peritoneal mucinous carcinomatosis (p<0.014).

Elias et al (2008) reported on the results of 105 consecutive patients with pseudomyxoma peritonei treated between 1994 and 2006 with CRS plus HIPEC. The primary tumor was the appendix in 93 patients, ovary in 3, urachus in 1, pancreas in 1, and indeterminate in 7. Tumor histology was disseminated peritoneal adenomucinosis in 48% of patients, intermediate in 35% and peritoneal mucinous carcinomatosis in 17%. At the end of the surgery, 72% of patients had no visible residual peritoneal lesions. The postoperative mortality rate was 7.6% and the morbidity rate was 67.6%. The median follow-up was 48 months, and 5-year OS and PFS rates were 80% (95% confidence interval [CI], 68% to 88%) and 68% (95% CI, 55% to 79%), respectively. On multivariate analysis, 2
factors had a negative influence on DFS: serum carbohydrate antigen 19-9 level (a marker of biliopancreatic malignancy) greater than 300 units/mL and nondisseminated peritoneal adenomucinosis tumor histology.

Table 2. Primary and Recurrence Study Results for CRS Plus HIPEC in Pseudomyxoma Peritonei

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Postoperative Mortality/Morbidity, %</th>
<th>Median OS, mo</th>
<th>5-Year OS, %</th>
<th>Median PFS, m</th>
<th>5-Year PFS, %</th>
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<td>Jimenez et al (2014)</td>
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<td>44</td>
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<tr>
<td>LG tumor</td>
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<td>Not reached</td>
<td>83</td>
<td>NR</td>
<td>58</td>
</tr>
<tr>
<td>Marcotte et al (2014)</td>
<td>58</td>
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<td>NR</td>
<td>77</td>
<td>NR</td>
<td>50</td>
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<td>Glehen et al (2010)</td>
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<td>4/40</td>
<td>34</td>
<td>73</td>
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<td>56</td>
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<td>Vaia et al (2009)</td>
<td>60</td>
<td>0/45</td>
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<td>94</td>
<td>NR</td>
<td>80</td>
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<tr>
<td>Elias et al (2008)</td>
<td>105</td>
<td>8/68</td>
<td>&gt;100</td>
<td>80</td>
<td>NR</td>
<td>68</td>
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<td>Yan et al (2007) (SR)</td>
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<td>NR</td>
<td>51-156</td>
<td>52-96</td>
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<td>Recurrence</td>
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<tr>
<td>Lord et al (2015)</td>
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<td>129.5</td>
<td>79</td>
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<td>Sardi et al (2013)</td>
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<td>0/42</td>
<td>NR</td>
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</table>

CRS: cytoreductive surgery; HG: high-grade tumor (peritoneal mucinous carcinomatosis); HIPEC: hyperthermic intraperitoneal chemotherapy; LG: low-grade tumor (disseminated peritoneal adenomucinosis); NR: not reported; OS: overall survival; PFS: progression-free survival; SR: systematic review.

a Median OS not reached with mean follow-up of 36 months.
b Five-year disease-free survival.
c Data from Lord et al (2015) represents 35 patients who had recurrence and redo CRS plus HIPEC out of 512 patients in the total study cohort.
d Results after second procedure shown.
e Mean OS.

Recurrence

From the same U.S. medical center database studied by Jimenez et al (2014; previously described), Sardi et al (2013) identified 26 patients who underwent repeat CRS plus HIPEC for peritoneal carcinomatosis recurrence.19, Sixteen (62%) patients had high-grade peritoneal mucinous carcinomatosis and 10 (38%) patients had low-grade disseminated peritoneal adenomucinosis. Patients eligible for repeat CRS plus HIPEC had Eastern Cooperative Oncology Group Performance Status scores of 0 or 1. The proportion of patients who had a preoperative PCI score of less than 20 was 35% before the second procedure and 75% before the third procedure (1/4 patients). There were no 30-day postoperative deaths; postoperative morbidity was 42% after the second procedure and 50% after the third procedure. After the second procedure, 1-, 3-, and 5-year OS rates were 91%, 53%, and 34%, respectively. After the third procedure, the 1-year OS rate was 75%.

Lord et al (2015) reported on a retrospective cohort study of 512 patients with perforated appendiceal tumors and pseudomyxoma peritonei who received CRS plus HIPEC at a single-center in the U.K. and achieved complete cytoreduction.18, Thirty-five (26%) of 137 patients who experienced recurrence underwent repeat CRS plus HIPEC; median time to recurrence was 26 months. Complete cytoreduction was achieved (again) in 20 (57%) patients. The mean OS in
patients without recurrence (n=375); patients who recurred and had repeat CRS plus HIPEC (n=35), and patients who recurred but did not have repeat CRS plus HIPEC (n=102) was 171 months (95% CI, 164 to 178 months), 130 months (95% CI, 105 to 153 months), and 101 months (95% CI, 84 to 119 months) across the 3 groups, respectively (p=0.001). Five-year survival rates were 91%, 79%, and 65%, respectively. The incidence of complications was similar between primary and repeat procedures.

Section Summary: Pseudomyxoma Peritonei
Large, retrospective cohort studies and systematic reviews have reported median survival ranging from 47 to 156 months and 5-year OS rates range from 41% to 96% for patients with primary treatment for pseudomyxoma peritonei treated with CRS plus HIPEC. Two retrospective studies reported results of CRS plus HIPEC for recurrence with 5-year OS rates of 34% and 79%. Procedure-related morbidity and mortality have generally decreased over time.

Peritoneal Carcinomatosis of Colorectal Origin
Clinical Context and Therapy Purpose
The purpose of CRS plus HIPEC in patients who have peritoneal carcinomatosis of colorectal origin is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of CRS plus HIPEC improve the net health outcome in those with peritoneal carcinomatosis of colorectal origin?

The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with peritoneal carcinomatosis of colorectal origin.

Interventions
The combination therapy being considered is CRS plus HIPEC.

Comparators
The following therapies are currently being used to treat individuals with peritoneal carcinomatosis of colorectal origin: CRS alone and systemic chemotherapy.

Outcomes
The general outcomes of interest are PFS, OS, and postoperative morbidity.

Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

Systematic Reviews
Huang et al (2017) published a systematic review and meta-analysis of studies assessing CRS plus HIPEC in patients with peritoneal carcinomatosis from colorectal cancer.20 Reviewers included 76 studies published between 1993 and 2016. Fifteen studies were controlled, 1 of which was an RCT, and 61 were uncontrolled studies. In a meta-analysis of the controlled studies, there was a significantly higher survival rate in patients who received CRS plus HIPEC compared with standard therapy (e.g., palliative surgery alone or with systemic chemotherapy) (pooled hazard ratio [HR], 2.67, 95% CI, 2.21 to 3.23; I²=0%, p<0.001). In sensitivity analyses, date of publication, geographic location of study conduct, and chemotherapy regimen used in the HIPEC procedure did not have a significant impact. In the controlled studies, the mean mortality rate was 4.3% in the CRS plus HIPEC group compared with 6.2% in the traditional treatment group (p=0.423). The mean morbidity rate was 19.8% in the CRS plus HIPEC group and 20.5% in the traditional treatment group (p=0.815). In all 76 studies, the mean mortality rate was 2.8% and mean morbidity rate was 33%.
Two systematic reviews published in 2014 examined QOL outcomes in patients with peritoneal carcinomatosis who underwent CRS plus HIPEC.21,22 Both reviews included studies that used structured QOL scales; Shan et al (2014) included 15 studies (total n=1583 patients), 14 of which appeared in the review of 20 studies (n=1181 patients) by Seretis et al (2014).22 No RCTs were identified. Studies were heterogeneous in terms of sample sizes (median, >60 patients; range, 5-216 patients), response rates (most <85%), primary cancers (e.g., gastrointestinal, ovarian, endometrial, mesothelioma), QOL scales, and timing of QOL evaluations. Nonetheless, both reviews reported a decline in health-related QOL compared with baseline values up to four months posttreatment. At one year, QOL scores improved to baseline values or above. In a random-effects meta-analysis of 8 studies (n=499 patients), overall health ($I^2=38\%$) and emotional health ($I^2=41\%$) showed statistically significant improvements compared with baseline, but physical ($I^2=60\%$), social ($I^2=0\%$), and functional ($I^2=74\%$) health did not.21 Improvements were small to medium (standardized mean difference, <0.4 for all outcomes). Although this evidence would suggest improvements from baseline in some QOL domains, the absence of parallel control groups limits interpretation of the results.

**Randomized Controlled Trials**

One RCT has been published. A trial by Verwaal et al (2003), included in Huang et al (2017), who randomized 105 patients with peritoneal carcinomatosis to standard treatment with systemic chemotherapy (fluorouracil and leucovorin) and palliative surgery, if necessary (i.e., treatment of bowel obstruction), or to CRS plus HIPEC followed by standard systemic chemotherapy.23, Patients with other sites of metastases (i.e., lung or liver) were excluded.

The primary endpoint was OS, measured from the time of randomization to death from any cause. After a median follow-up of 21.6 months, 20 (39\%) of 51 patients in the standard therapy group were still alive compared with 30 (55\%) of 54 patients in the cyto-reduction group (HR for death, 0.55; 95\% CI, 0.32 to 0.95; $p=0.032$). The median OS in the control group was 12.6 months compared with 22.4 months in the cyto-reduction group. Subgroup analysis revealed that OS was particularly poor among patients with a residual tumor measuring greater than 2.5 mm and in patients with tumor involvement in six or more regions in the abdomen. In these groups, median survival was approximately 5 months compared with 29 months in patients with no residual tumor.

In the cyto-reduction group, four (8\%) patients died from treatment. The most important complications were small bowel leakage and abdominal sepsis; the most common grade 3 and 4 adverse events were leukopenia (7 [15\%] patients) and gastrointestinal fistula (7 [15\%] patients), respectively.

Verwaal et al (2008) reported on the 8-year follow-up to the RCT and evaluated all patients alive until 2007.24 Minimum follow-up was six years (median, 7.8 years; range, 6-9.6 years). During follow-up, 1 patient crossed over from the standard arm to the CRS plus HIPEC arm after recurrent disease 30 months post randomization. The median disease-specific survival was 12.6 months in the standard arm and 22.2 months in the CRS plus HIPEC arm ($p=0.028$). Median PFS was 7.7 months in the standard arm and 12.6 months in the CRS plus HIPEC arm ($p=0.02$).

**Section Summary: Peritoneal Carcinomatosis of Colorectal Origin**

One RCT, a number of observational studies, and systematic reviews of these studies have been published. A 2017 systematic review included 76 studies, of which 15 were controlled and 1 was an RCT. In a meta-analysis of the controlled studies, there was a significantly higher survival rate in patients who received CRS plus HIPEC compared with standard therapy (e.g., palliative surgery alone or with systemic chemotherapy). Also, in the controlled studies, CRS plus HIPEC was not associated with a significantly higher rate of treatment-related morbidity. The RCT, in which patients were followed for at least six years, demonstrated improved survival in patients with peritoneal carcinomatosis due to colorectal cancer who received CRS plus HIPEC and systemic chemotherapy compared with patients who received systemic chemotherapy alone. At the 8-year follow-up, disease-specific survival was 22.2 months in the CRS plus HIPEC arm and 12.6
months in the control arm. However, procedure-related morbidity and mortality were relatively high; 4 (8%) patients in the CRS plus HIPEC group died from treatment.

Peritoneal Carcinomatosis of Gastric Origin
Clinical Context and Therapy Purpose
The purpose of CRS plus HIPEC in patients who have peritoneal carcinomatosis of gastric origin is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in those with peritoneal carcinomatosis of gastric origin?

The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with peritoneal carcinomatosis of gastric origin.

Interventions
The combination therapy being considered is CRS plus HIPEC.

Comparators
The following therapies are currently being used to treat peritoneal carcinomatosis of gastric origin: CRS alone and systemic chemotherapy.

Outcomes
The general outcomes of interest are PFS, OS, and postoperative morbidity.

Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

Systematic Reviews
Desiderio et al (2017) published a meta-analysis of controlled studies comparing CRS plus HIPEC with standard surgical management in the treatment of advanced gastric cancer. A separate analysis was conducted of studies focused on patients with and without peritoneal carcinomatosis. For the treatment of patients with peritoneal carcinomatosis of gastric origin, reviewers identified 2 small RCTs (discussed below) and 12 controlled nonrandomized studies. In a meta-analysis of survival at 1 year, there was a significantly higher survival rate in the group receiving HIPEC than control treatment (relative risk, 0.67; 95% CI, 0.52 to 0.86; p=0.002). However, there was no significant difference between HIPEC and control groups in 2-year survival (relative risk, 0.87; 95% CI, 0.73 to 1.04; p=0.12) or 3-year survival (relative risk, 0.99; 95% CI, 0.93 to 1.06; p=0.85).

Randomized Controlled Trials
Rudloff et al (2014) reported on results of a preliminary, open-label, RCT in 17 patients from several U.S. centers who had gastric cancer metastatic to the liver and lung and peritoneal carcinomatosis. Eligible patients could, in the opinion of the principal investigator, be resected to "no evidence of disease" based on imaging studies or staging laparoscopy. Patients were assigned using a computerized randomization algorithm to systemic chemotherapy (n=8) or to systemic chemotherapy plus gastrectomy and CRS plus HIPEC (n=9). Median and 1-year OS were 4.3 months and 0% respectively, in the control group, and 11.3 months and 78% respectively, in the CRS plus HIPEC group (statistical testing not reported). Factors associated with survival more than 1 year in the CRS plus HIPEC group were complete cytoreduction and initial PCI score of 15 or less. Enrollment to complete a larger planned trial was discontinued due to slow accrual.
Yang et al (2011) randomized 68 patients (1:1) to CRS plus HIPEC or to CRS alone. Median OS was 11.0 months (95% CI, 10.0 to 11.9 months) in the CRS plus HIPEC group and 6.5 months (95% CI, 4.8 to 8.2 months) in the CRS-only group (p=0.046). One-, 2-, and 3-year OS rates in the CRS plus HIPEC and CRS-only groups were 41.2% and 29.4%, 14.7% and 5.9%, and 5.9% and 0%, respectively. The incidence of serious adverse events was similar between groups (15% in the CRS plus HIPEC group vs 12% in the CRS-only group).

**Section Summary: Peritoneal Carcinomatosis of Gastric Origin**
A 2017 meta-analysis identified 2 RCTs and 12 controlled nonrandomized studies comparing CRS plus HIPEC with standard surgical management in patients with peritoneal carcinomatosis due to gastric cancer. The meta-analysis found significantly increased rates of survival in the CRS plus HIPEC group at one year but there was no difference in survival rates at two or three years. One small (n=17) preliminary RCT showed improved survival in patients with peritoneal carcinomatosis due to gastric cancer who received CRS plus HIPEC compared with patients who received chemotherapy alone. Another (n=68) RCT showed improved survival in patients who received CRS plus HIPEC compared with CRS alone. Additional study in a larger sample is needed.

**Peritoneal Carcinomatosis From Endometrial Cancer**

**Clinical Context and Therapy Purpose**
The purpose of CRS plus HIPEC in patients who have peritoneal carcinomatosis of endometrial origin is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in those with peritoneal carcinomatosis of endometrial origin?

The following PICOs were used to select literature to inform this review.

**Patients**
The relevant population of interest are individuals with peritoneal carcinomatosis of endometrial origin.

**Interventions**
The combination therapy being considered is CRS plus HIPEC.

**Comparators**
The following therapies are currently being used to treat peritoneal carcinomatosis of endometrial origin: CRS alone and systemic chemotherapy.

**Outcomes**
The general outcomes of interest are PFS, OS, and postoperative morbidity. Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

**Cohort Studies**
No RCTs or nonrandomized comparative studies were identified. Three small, non-U.S. cohort studies reported outcomes for CRS plus HIPEC for primary (n=6 patients) or recurrent (confined to the peritoneum; n=18 patients) endometrial cancer with peritoneal carcinomatosis. Patients varied in a histopathologic subtype of cancer, prior treatment, the interval from initial treatment to CRS plus HIPEC (range, 0-120 months), preoperative PCI score (range, 3-24), and postoperative treatment. All patients underwent CRS and HIPEC. Cytoreduction was complete in 18 (75%) patients and almost complete (minimal residual disease) in 3 (12.5%) patients. Of 24 total patients, 5 (21%) died within 1 year (comparable to published survival estimates with systemic chemotherapy); 3 (12.5%) died at 12 to 19 months; 11 (46%) were alive and disease-free at the time of publication (median, 34 months; range, 2-125 months); and 4 (17%) were alive with recurrent disease (median, 21 months; range, 6-28 months). (One patient was lost to follow-up.)
The largest study of 13 patients with primary or recurrent disease reported a median OS of 19 months and a median DFS of 11 months. In all patients, grade 1 adverse events included anastomotic leak and cisplatin neurotoxicity. More severe complications occurred in 5 (21%) patients and included grade 4 septicemia and pulmonary embolism; pancytopenia and critical illness myopathy; and chronic renal failure. PCI score and completeness of cytoreduction were associated with survival.

Section Summary: Peritoneal Carcinomatosis From Endometrial Cancer
Cohort studies including 24 patients with primary or recurrent endometrial cancer and peritoneal carcinomatosis have suggested that survival with CRS plus HIPEC may be better than systemic chemotherapy (median OS, 19 months vs <12 months in published reports). However, severe complications occurred in 21% of patients. Further, absent parallel control groups, potential bias was introduced by confounding factors, such as disease history, cancer subtype, preoperative PCI score, and treatment. Randomized trials comparing CRS plus HIPEC with standard treatment (surgery [including CRS], systemic chemotherapy, brachytherapy, radiotherapy, and/or hormone therapy) in larger numbers of patients are needed.

Peritoneal Mesothelioma
Clinical Context and Therapy Purpose
The purpose of CRS plus HIPEC in patients who have peritoneal mesothelioma is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in those with peritoneal mesothelioma?

The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with peritoneal mesothelioma.

Interventions
The combination therapy being considered is CRS plus HIPEC.

Comparators
The following therapies are currently being used to treat peritoneal mesothelioma: CRS alone and systemic chemotherapy.

Outcomes
The general outcomes of interest are PFS, OS, and postoperative morbidity. Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

Systematic Reviews
For a systematic review, Baratti et al (2011) searched the PubMed database for studies on the clinical management of diffuse malignant peritoneal mesothelioma. They included 14 studies with a total of 427 patients, 289 of whom underwent CRS plus HIPEC with 106 receiving both HIPEC and early postoperative intraperitoneal chemotherapy. Studies that included patients with well-differentiated or low-grade types of mesothelioma were excluded. All selected studies were prospective, uncontrolled case series. The mean patient age ranged from 49 to 56 years. All institutions used peritonectomy and multivisceral resection to remove the visible disease. HIPEC protocols varied widely across institutions in terms of techniques, drugs, carriers, timing, and temperatures. Operative mortality and morbidity were reported in 11 single-institution case series. Operative mortality rates ranged from 0% to 10.5%. Overall, death occurred in 11 (3.1%) of 373 assessable patients. In a multi-institutional series, mortality was 2.2%. Morbidity (severe and life-threatening complications) varied from 20% to 41% for patients who underwent CRS plus HIPEC, median OS ranged from 29.5 to 92 months. The median OS was not reached in 3 series.
but exceeded 100 months in one of them. One-, 2-, 3-, and 5-year OS rates varied from 43% to 88%, 43% to 77%, 43% to 70%, and 33% to 68%, respectively. In 4 studies, median PFS ranged from 7.2 to 40 months.

Results of a systematic review by Helm et al (2015), which included 7 studies published after the Baratti et al (2011) review, aligned with Baratti’s findings: pooled 1-, 3-, and 5-year survival estimates were 84%, 59%, and 42%, respectively.30

**Observational Studies**
Table 3 summarizes relevant observational studies on peritoneal mesothelioma, some of which are discussed next.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Postoperative, %</th>
<th>Median OS, mo</th>
<th>5-Year OS, %</th>
<th>Median PFS, mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robella et al (2014)</td>
<td>42</td>
<td>7</td>
<td>65</td>
<td>44</td>
<td>NR</td>
</tr>
<tr>
<td>Alexander et al (2013)</td>
<td>211</td>
<td>2</td>
<td>38</td>
<td>41</td>
<td>NR</td>
</tr>
<tr>
<td>Glehen et al (2010)</td>
<td>88</td>
<td>NR</td>
<td>41</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Yan et al (2009)</td>
<td>401</td>
<td>NR</td>
<td>53</td>
<td>47</td>
<td>NR</td>
</tr>
</tbody>
</table>

CRS: cytoreductive surgery; HIPEC: hyperthermic intraperitoneal chemotherapy; NR: not reported; OS: overall survival; PFS: progression-free survival.

The largest observational study (and included in both systematic reviews) was an international registry study by Yan et al (2009), for which 401 (99%) patients had a complete follow-up.33 Of these patients, 92% received HIPEC. Median and 1-, 3-, and 5-year survival rates were 53 months, 81%, 60%, and 47%, respectively.

Alexander et al (2013) reported on 211 patients from 3 U.S. tertiary care centers who had malignant peritoneal mesothelioma and had undergone CRS plus HIPEC.32 On multivariate analysis, factors statistically associated with favorable outcome were age younger than 60 years, complete or almost complete cytoreduction, low histologic grade, and HIPEC with cisplatin (rather than mitomycin C).

In the retrospective, multicenter cohort study by Glehen et al (2010), discussed in the Pseudomyxoma Peritonei section, the principal origin of the tumor was peritoneal mesothelioma in 88 patients.12 The median survival for this group of patients was 41 months. Independent prognostic indicators in multivariate analysis were: institution, the origin of peritoneal carcinomatosis, completeness of CRS, the extent of carcinomatosis, and lymph node involvement.

**Section Summary: Peritoneal Mesothelioma**
Retrospective cohort studies have shown median and 5-year OS ranged from 30 to 92 months and from 33% to 68% respectively, for patients with peritoneal mesothelioma treated with CRS plus HIPEC. Two studies indicated improved outcomes with platinum-containing HIPEC (cisplatin or carboplatin) compared with mitomycin C. Procedure-related morbidity and mortality rates have remained relatively steady over time, at approximately 35% and 5% respectively.

**Newly Diagnosed Stage III Ovarian Cancer**

**Clinical Context and Therapy Purpose**
The purpose of CRS plus HIPEC in patients who have newly diagnosed stage III ovarian cancer is to provide a treatment option that is an alternative to or an improvement on existing therapies. The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in those with ovarian cancer?
The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with newly diagnosed stage III ovarian cancer.

Interventions
The combination therapy being considered is CRS plus HIPEC.

Comparators
The following therapies are currently being used to treat ovarian cancer: CRS alone and systemic chemotherapy.

Outcomes
The general outcomes of interest are PFS, OS, and postoperative morbidity. Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

Systematic Reviews
Zhang et al (2019) published a systematic review and meta-analysis assessing the impact of HIPEC on patients with ovarian cancer.\textsuperscript{45} Thirteen studies (range of patients, 12-122), with patients with advanced (stage IC-IV) primary ovarian cancer, were included. Groups treated with HIPEC had a better OS (HR 0.59, 95% CI 0.46-0.72) and PFS (HR 0.41, 95% CI 0.32-0.54) than those who did not receive HIPEC. The review was limited by the inclusion of only English language studies, the small number of RCTs (n=2) identified for inclusion, and only one of the included studies reporting information about adverse events.

Wang et al (2019) published a systematic review analyzing the effects of HIPEC and CRS for ovarian cancer patients.\textsuperscript{46} Thirteen studies, all but 3 of which were also used in Zhang et al (2019), were included in the review. In a subgroup analysis of patients with primary ovarian cancer, OS (HR 0.57, 95% CI 0.40-0.83, p=0.04) and DFS (HR 0.61, 95% CI 0.47-0.80, p<0.01) were significantly improved for the HIPEC group. The study was limited by the level of heterogeneity among the study populations and by some of the included studies not reporting morbidity for the control group.

Randomized Controlled Trials
One RCT has been published on CRS plus HIPEC for ovarian cancer (see Table 3). Van Driel et al (2018) reported that CRS plus HIPEC reduced mortality for patients with newly diagnosed stage III epithelial ovarian cancer (see Table 5).\textsuperscript{36} Disease recurrence or death occurred in 81% of patients treated with CRS plus HIPEC compared with 89% treated with CRS alone. At 5-year follow-up, 50% of patients treated with CRS plus HIPEC had died compared with 62% treated with CRS alone (p=0.02). Median OS was 45.7 months in the HIPEC group and 33.9 months in the control group. The incidence of grade 3 or 4 adverse events was similar in both groups (25% for surgery alone vs 27% for CRS plus HIPEC; p=0.76).

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Driel et al (2018)\textsuperscript{36}</td>
<td>EU</td>
<td>8</td>
<td>2007-2017</td>
<td>245 women with newly diagnosed stage III epithelial ovarian cancer after 3 cycles of carboplatin and paclitaxel and complete or optimal cytoreduction</td>
<td>122 patients received CRS plus HIPEC; 123 patients received CRS alone</td>
</tr>
</tbody>
</table>

CRS: cytoreductive surgery; HIPEC: hyperthermic intraperitoneal chemotherapy; RCT: randomized controlled trial.
Table 5. Summary of Key RCT Results

<table>
<thead>
<tr>
<th>Study</th>
<th>Disease Recurrence or Death, n (%)</th>
<th>Median RFS, mo</th>
<th>Mortality at Median of 4.7 Years, n (%)</th>
<th>Median OS, mo</th>
<th>Grade 3 or 4 AEs, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Driel et al (2018)³⁶</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>245</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRS alone</td>
<td>110 (89)</td>
<td>10.7</td>
<td>76 (62)</td>
<td>33.9</td>
<td>25</td>
</tr>
<tr>
<td>CRS plus HIPEC</td>
<td>99 (81)</td>
<td>14.2</td>
<td>61 (50)</td>
<td>45.7</td>
<td>27</td>
</tr>
<tr>
<td>HR (95% CI)</td>
<td>0.66 (0.50 to 0.87)</td>
<td>0.67 (0.48 to 0.94)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>0.003</td>
<td>0.02</td>
<td></td>
<td>0.76</td>
<td></td>
</tr>
</tbody>
</table>

AE: adverse event; CI: confidence interval; CRS: cytoreductive surgery; HIPEC: hyperthermic intraperitoneal chemotherapy; HR: hazard ratio; OS: overall survival; RCT: randomized controlled trial; RFS: recurrence-free survival (disease recurrence or progression or death).

The purpose of the limitations tables (see Tables 5 and 6) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement. The major limitation of the van Driel et al (2018) trial was the lack of blinding, which might be expected to have a minor effect on the objective measure of mortality.

Table 6. Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Populationa</th>
<th>Interventionb</th>
<th>Comparatorc</th>
<th>Outcomesd</th>
<th>Follow-Up²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Driel et al (2018)³⁶</td>
<td>4. There were very selective inclusion criteria, so the effect of the intervention on a broader patient population (e.g., recurrent disease) is unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

² Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 7. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocationa</th>
<th>Blindingb</th>
<th>Selective Reportingc</th>
<th>Data Completenessd</th>
<th>Powere</th>
<th>Statisticalf</th>
</tr>
</thead>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.


d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
Summary: Newly Diagnosed Stage III Ovarian Cancer
Evidence for HIPEC includes systematic reviews and an RCT in patients with newly diagnosed stage III epithelial ovarian cancer who were treated with neoadjuvant chemotherapy and had complete or optimal cytoreduction. HIPEC increased the time to disease recurrence and reduced mortality. HIPEC did not increase serious adverse events compared with surgery alone. The major limitation in the trial was the lack of blinding, which might be expected to have a minor effect on the objective measure of mortality.

Recurrent Stage III or IV Ovarian Cancer
Clinical Context and Therapy Purpose
The purpose of CRS plus HIPEC in patients who have recurrent ovarian cancer is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in patients with recurrent stage III or IV ovarian cancer?
The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are individuals with recurrent stage III or IV ovarian cancer.

Interventions
The combination therapy being considered is CRS plus HIPEC.

Comparators
The following therapies are currently being used to treat ovarian cancer: CRS alone and systemic chemotherapy.

Outcomes
The general outcomes of interest are PFS, OS, and postoperative morbidity. Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

Systematic Reviews
A systematic review and meta-analysis of studies assessing CRS plus HIPEC for treating ovarian cancer were published by Huo et al (2015).37, Reviewers selected studies that included more than ten patients with primary or recurrent ovarian cancer who were treated with CRS plus HIPEC. Thirty-seven studies were identified, 9 comparative studies and 28 uncontrolled studies. Only 1 RCT (Spiliotis et al [2015]38,), described below, was identified in the literature search. A pooled analysis of 8 studies comparing CRS plus HIPEC with CRS plus non-HIPEC chemotherapy found significantly higher 1-year survival in the CRS plus HIPEC group (odds ratio, 4.24; 95% CI, 2.17 to 8.30). There were similar findings on 3-year survival (pooled odds ratio, 4.31; 95% CI, 2.11 to 8.11). Most of the comparative studies were not randomized and thus subject to potential selection and observational biases.

Zhang et al (2019; see previous indication) also included results for patients with recurrent ovarian cancer.45, In this subgroup, HIPEC had significantly improved OS (HR 0.45, 95% CI 0.24-0.83) compared with groups that did not receive HIPEC, however, PFS (HR 0.55, 95% CI 0.27-1.11) was not significantly improved.

Wang et al (2019; see previous indication) also provided a subgroup analysis of patients with recurrent ovarian cancer.46, In this population, the HIPEC group had significantly improved OS (HR 0.48, 95% CI 0.24-0.96, p<0.01) but not DFS (HR 0.59, 95% CI 0.33-1.08, p=0.09).
Randomized Controlled Trials

Spiliotis et al (2015) reported on a single-center RCT of 120 women who had recurrent stage IIIC or IV ovarian cancer after surgery and systemic chemotherapy (see Table 8). In Kaplan-Meier survival analysis, mean OS was 26.7 months in the CRS plus HIPEC group and 13.4 months in the non-HIPEC group (p=0.006) (see Table 8). However, completeness of cytoreduction and PCI score were associated with survival, and these measures were not comparable between groups. Treatment-related morbidity and mortality were not reported.

Table 8. Summary of Key RCT Characteristics

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiliotis et al (2015)</td>
<td>EU</td>
<td>1</td>
<td>2006-2013</td>
<td>120 women with advanced (stage IIIC-IV) recurrent epithelial ovarian cancer</td>
<td>CRS plus HIPEC CRS plus systemic chemotherapy</td>
</tr>
</tbody>
</table>

CRS: cytoreductive surgery; HIPEC: hyperthermic intraperitoneal chemotherapy; RCT: randomized controlled trial.

Table 9. Summary of Key RCT Results

<table>
<thead>
<tr>
<th>Study</th>
<th>Disease Recurrence or Death, n (%)</th>
<th>Median RFS, mo</th>
<th>Mortality at Median of 4.7 Years, n (%)</th>
<th>Median OS, mo</th>
<th>Grade 3 or 4 AEs, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRS plus SC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRS plus HIPEC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AE: adverse event; CRS: cytoreductive surgery; HIPEC: hyperthermic intraperitoneal chemotherapy; OS: overall survival; RCT: randomized controlled trial; RFS: recurrence-free survival (disease recurrence or progression or death); SC: systemic chemotherapy.

Limitations in relevance and design and conduct are noted in Tables 9 and 10. For the Spiliotis et al (2015) study, baseline between-group differences in the stage of disease and completeness of cytoreduction, which is a prognostic indicator for survival, limit interpretation of the trial results.

Table 10. Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiliotis et al (2015)</td>
<td>3. The HIPEC group had more patients with stage IIIC disease (68% vs 60%)</td>
<td>3. More patients in the HIPEC group had complete cytoreduction (65% vs 55%).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

HIPEC: hyperthermic intraperitoneal chemotherapy.

Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not pre specified; 6. Clinical significant difference not supported.

Table 11. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation</th>
<th>Blinding</th>
<th>Selective Reporting</th>
<th>Data Completeness</th>
<th>Power</th>
<th>Statistical</th>
</tr>
</thead>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

- Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
- Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
- Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Section Summary: Recurrent Stage IIIC or IV Ovarian Cancer

CRS plus HIPEC has been studied in an RCT of patients with recurrent stage IIIC or IV ovarian cancer. For recurrent disease (second-line setting), evidence from an RCT indicated that CRS plus HIPEC improved survival compared with CRS without HIPEC. Treatment groups in this RCT were unbalanced at baseline and in the completeness of cytoreduction, which has consistently been shown to be associated with survival.

Appendiceal Goblet Cell Tumors

Clinical Context and Therapy Purpose

The purpose of CRS plus HIPEC in patients who have appendiceal goblet cell tumors is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of HIPEC improve the net health outcome in those with appendiceal goblet cell tumors?

The following PICOs were used to select literature to inform this review.

- Patients
  The relevant population of interest are individuals with appendiceal goblet cell tumors.

- Interventions
  The combination therapy being considered is CRS plus HIPEC.

- Comparators
  The following therapies are currently being used to treat appendiceal goblet cell tumors: CRS alone and systemic chemotherapy.

- Outcomes
  The general outcomes of interest are PFS, OS, and postoperative morbidity. Morbidity and mortality from the procedure are measured in the early postoperative period. PFS and OS are should be measured out to five years.

- Cohort Studies
  In a multicenter, retrospective cohort study, McConnell et al (2014) studied appendiceal goblet cell tumors (n=45) and compared outcomes for CRS plus HIPEC with those in nonmucinous (n=52) and low-grade (n=567) and high-grade (n=89) mucinous appendiceal tumors.³⁹ All patients had peritoneal malignancy due to advanced disease but none was identified as...
having pseudomyxoma peritonei. With a median follow-up of 49 months, patients with goblet cell tumors had better survival outcomes than those in patients with low-grade mucinous tumors and similar outcomes to those in patients with high-grade mucinous tumors. 3-year OS rates in patients with goblet cell, low-grade mucinous, high-grade mucinous, and nonmucinous tumor were 63%, 81% (p=0.003), 40% (p=0.07), and 52% (p=0.48), respectively. In 489 (65%) patients who achieved complete cytoreduction, the pattern of 3-year DFS outcomes was similar: 43%, 73% (p<0.001), 44% (p=0.85), and 44% (p=0.82), respectively (p values for rates vs goblet cell tumors). Treatment-related adverse events were not reported. Grade 3 or 4 surgical complications occurred in approximately 20% of patients in each group.

Section Summary: Appendiceal Goblet Cell Tumors
Evidence is limited to a retrospective cohort study of patients with goblet cell tumors of the appendix. This study found a 3-year survival rate of 63% for CRS plus HIPEC.

Summary of Evidence
For individuals who have pseudomyxoma peritonei who receive CRS plus HIPEC, the evidence includes cohort studies and a systematic review. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. Uncontrolled studies of primary treatment of pseudomyxoma peritonei with CRS plus HIPEC have reported a median and a 5-year OS ranging from 47 to 156 months and 41% to 96%, respectively. Two small retrospective studies, who underwent CRS plus HIPEC for recurrence, indicated 5-year OS rates ranging from 34% to 79%. Procedure-related morbidity and mortality have decreased over time. Controlled studies are needed to draw conclusions about the efficacy and safety of CRS plus HIPEC compared with standard treatment (CRS alone). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have peritoneal carcinomatosis of colorectal origin who receive CRS plus HIPEC, the evidence includes an RCT, systematic reviews, and a large number of observational studies. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. A meta-analysis of controlled studies found that CRS plus HIPEC, compared with traditional therapy without HIPEC, was associated with significantly higher survival rates and was not associated with significantly higher treatment-related morbidity rates. The RCT, in which patients with peritoneal carcinomatosis due to colorectal cancer were followed for at least six years, demonstrated improved survival in patients who received CRS plus HIPEC and systemic chemotherapy compared with patients who received systemic chemotherapy alone. However, procedure-related morbidity and mortality rates were relatively high, and systemic chemotherapy regimens did not use currently available biologic agents. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have peritoneal carcinomatosis of gastric origin who receive CRS plus HIPEC, the evidence includes two small RCTs, observational studies, and a systematic review. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. A 2017 meta-analysis identified 2 RCTs and 12 controlled nonrandomized studies comparing surgery plus HIPEC with standard surgical management in patients who had peritoneal carcinomatosis due to gastric cancer. The meta-analysis found significantly better survival in the surgery plus HIPEC group at one year but not at two or three years. An RCT found better survival in patients who received CRS plus HIPEC compared with an alternative treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have peritoneal carcinomatosis of endometrial origin who receive CRS plus HIPEC, the evidence includes cohort studies. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. Only uncontrolled studies with small sample sizes were available (<25 patients). Randomized trials that compare CRS plus HIPEC with standard treatment (e.g., CRS alone or systemic chemotherapy alone) are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.
For individuals who have peritoneal mesothelioma who receive CRS plus HIPEC, the evidence includes retrospective cohort studies and systematic reviews. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. Uncontrolled studies have shown median and 5-year OS ranging from 30 to 92 months and 33% to 68%, respectively, for patients who had peritoneal mesothelioma treated with CRS plus HIPEC. Reported procedure-related morbidity and mortality were approximately 35% and 5%, respectively. Although no RCTs or comparative studies have been published, uncontrolled study data have shown reasonable rates of OS with the use of this technique. Procedure-related morbidity and mortality have remained steady over time. Because the prevalence of peritoneal mesothelioma is very low, conducting high-quality trials is difficult. Thus, although the evidence is insufficient to determine the effects of the technology on health outcomes, for the reasons discussed above, CRS plus HIPEC may be considered medically necessary for this indication.

For individuals who have newly diagnosed stage III ovarian cancer who receive CRS plus HIPEC, the evidence includes an RCT. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. For patients with newly diagnosed stage III ovarian cancer who had received neoadjuvant chemotherapy, HIPEC increased the time to disease recurrence and reduced mortality. HIPEC did not increase serious adverse events compared with surgery alone. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have recurrent stage IIIC or IV ovarian cancer who receive CRS plus HIPEC, the evidence includes an RCT and systematic review. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. For recurrent stage IIIC or IV disease (second-line setting), evidence from an RCT indicated that CRS plus HIPEC improved survival compared with CRS without HIPEC. However, interpretation of this study is limited because treatment groups in this RCT were unbalanced at baseline (variation in the completeness of cytoreduction), which has been shown to be associated with survival. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have appendiceal goblet cell tumors who receive CRS plus HIPEC, the evidence includes a case series. The relevant outcomes are OS, disease-specific survival, QOL, and treatment-related mortality and morbidity. One retrospective series was identified. Additional studies—preferably controlled and ideally, RCTs—are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Supplemental Information**

**Practice Guidelines and Position Statements**

**National Comprehensive Cancer Network**

The NCCN guidelines include the following relevant recommendation for colon cancer (v.2.2019): "The panel currently believes that complete cytoreductive surgery and/or intraperitoneal chemotherapy can be considered in experienced centers for selected patients with limited peritoneal metastases for whom R0 resection can be achieved. However, the significant morbidity and mortality associated with HIPEC, as well as the conflicting data on clinical efficacy, make this approach very controversial."40

The NCCN guidelines on gastric cancer (v.2.2019), uterine neoplasms (v.3.2019), and rectal cancer (v.2.2019) do not discuss cytoreductive surgery plus hyperthermic intraperitoneal chemotherapy (HIPEC).41,42,43

The NCCN guidelines on ovarian cancer (v.1.2019) state that "patients with low volume residual disease after surgical debulking for stage II or II invasive epithelial ovarian or peritoneal cancer are candidates for intraperitoneal (IP) chemotherapy."44 and "Hyperthermic intraperitoneal chemotherapy (HIPEC) with cisplatin (11 mg/m²) can be considered at the time of interval debulking surgery for stage III disease."
American Society of Colon and Rectal Surgeons
The practice guidelines on the treatment of colon cancer by the American Society of Colon and Rectal Surgeons (2017) stated that treatment of patients with isolated peritoneal carcinomatosis may include cytoreductive surgery in conjunction with perioperative intraperitoneal chemotherapy, with or without hyperthermia.45.

Society of Surgical Oncology
The Society of Surgical Oncology (2007) issued a consensus statement on cytoreductive surgery and HIPEC in the management of peritoneal surface malignancies of colonic origin.46. The Society recommended that patients with peritoneal carcinomatosis without distant disease, in whom complete cytoreduction is possible, undergo HIPEC before systemic therapy. As of July 2018, an updated statement has not been published.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently ongoing or unpublished trials that might influence this review are listed in Table 12.

Table 12. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Title</th>
<th>Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal and appendiceal cancer</td>
<td>ICARuS Post-operative Intraperitoneal Chemotherapy (EPIC) and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) After Optimal Cytoreductive Surgery (CRS) for Neoplasms of the Appendix, Colon or Rectum With Isolated Peritoneal Metastasis</td>
<td>220</td>
<td>Sep 2020</td>
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<tr>
<td>NCT01226394</td>
<td>Multicentric Phase III Trial Comparing Simple Follow-up to Exploratory Laparotomy Plus “in Principle” HIPEC (Hyperthermic Intraperitoneal Chemotherapy) in Colorectal Patients Initially Treated With Surgery and Adjuvant Chemotherapy Who Have a High Risk of Developing Colorectal Peritoneal Carcinomatosis</td>
<td>130</td>
<td>Jun 2019 (unknown)</td>
</tr>
<tr>
<td>NCT02614534</td>
<td>Multicentre, Randomized Clinical Trial to Evaluate Safety and Efficacy of Hyperthermic Intra-peritoneal Chemotherapy (HIPEC) With Mitomycin C Used During Surgery for Treatment of Locally Advanced Colorectal Carcinoma</td>
<td>200</td>
<td>Oct 2020</td>
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<tr>
<td>NCT02231086</td>
<td>Adjuvant Hyperthermic Intraperitoneal Chemotherapy in Patients With Colon Cancer at High Risk of Peritoneal Carcinomatosis</td>
<td>204</td>
<td>Apr 2022</td>
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<tr>
<td>NCT02179489</td>
<td>Randomized Multicentric Phase III Trial Comparing Simple Surgery to Surgery Plus HIPEC (Hyperthermic Intraperitoneal Chemotherapy) With MMC in Colorectal Patients Who Have a High Risk of Developing Colorectal Peritoneal Carcinomatosis</td>
<td>300</td>
<td>Oct 2023</td>
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<tr>
<td>Gastric cancer</td>
<td>A Phase III Study of Hyperthermic Intraperitoneal Chemotherapy in the Treatment of Locally Advanced Gastric Cancer After Radical Gastrectomy With D2 Lymphadenectomy</td>
<td>582</td>
<td>July 2019 (unknown)</td>
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<tr>
<td>NCT02240524</td>
<td>D2 Radical Resection After Neoadjuvant Chemotherapy Combined With HIPEC for Advanced Gastric Cancer</td>
<td>640</td>
<td>Dec 2019</td>
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<table>
<thead>
<tr>
<th>Clinical Trial ID</th>
<th>Trial Description</th>
<th>Efficacy Measure</th>
<th>Enrollment Date</th>
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<tbody>
<tr>
<td>NCT02158988</td>
<td>Gastric Cancer: a Prospective Randomized Controlled Trial</td>
<td>Prospective Multicenter Phase III Trial Using CRS With / Without HIPEC After Preoperative Chemotherapy in Patients With Peritoneal Carcinomatosis of Gastric Cancer Incl. Adenocarcinoma of the Esophagogastroduodenal Junction</td>
<td>180 Sep 2020</td>
</tr>
<tr>
<td>NCT01882933</td>
<td>GASTRICHIP: D2 Resection and HIPEC (Hyperthermic Intrapерitoneal Chemoperfusion) in Locally Advanced Gastric Carcinoma. A Randomized and Multicentric Phase III Study</td>
<td></td>
<td>322 May 2025</td>
</tr>
<tr>
<td><strong>Ovarian cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01628380</td>
<td>Stage III C Unresectable Epithelial Ovarian/Tubal Cancer With Partial or Complete Response After 1st Line Neoadjuvant Chemotherapy (3 Cycles CBDCA + Paclitaxel): a Phase III Prospective Randomized Study Comparing Cytoreductive Surgery + Hyperthermic Intrapерitoneal Chemotherapy (CDDP + Paclitaxel) + 3 Cycles CBDCA + Paclitaxel vs Cytoreductive Surgery Alone + 3 Cycles CBDCA + Paclitaxel</td>
<td>94 Jul 2018 (unknown)</td>
<td></td>
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<tr>
<td>NCT01539785</td>
<td>Surgery Plus Hyperthermic Intra-peritoneal Chemotherapy (HIPEC) Versus Surgery Alone in Patients With Platinum-sensitive First Recurrence of Ovarian Cancer: a Prospective Randomized Multicenter Trial</td>
<td>158 Sep 2018 (unknown)</td>
<td></td>
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<tr>
<td>NCT01767675</td>
<td>A Phase II Randomized Study: Outcomes After Secondary Cytoreductive Surgery With or Without Carboplatin Hyperthermic Intrapерitoneal Chemotherapy (HIPEC) Followed by Systemic Combination Chemotherapy for Recurrent Platinum-Sensitive Ovarian, Fallopian Tube, or Primary Peritoneal Cancer</td>
<td>98 Jan 2020</td>
<td></td>
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<tr>
<td>NCT02124421</td>
<td>Phase II Randomized Study: Cytoreductive Surgery (CRS) With/Without Carboplatin Hyperthermic Intrapерitoneal Chemotherapy (HIPEC) Followed by Adjuvant Chemotherapy as Initial Treatment of Ovarian, Fallopian Tube, &amp; Primary Peritoneal Cancer</td>
<td>48 Apr 2020</td>
<td></td>
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<tr>
<td>NCT01376752</td>
<td>A Phase III Randomized Study Evaluating Hyperthermic Intra-Peritoneal Chemotherapy (HIPEC) in the Treatment of Relapse Ovarian Cancer</td>
<td>444 Apr 2025</td>
<td></td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

**References**


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Documentation for Clinical Review

Please provide the following documentation (if/when requested):

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - History of disease processes and treatment
  - Past and present diagnostic testing and results
  - Recurrent cancers
  - Surgery history (if applicable)
  - Chemotherapy use (if applicable)
- Radiology report(s) and interpretation (i.e., MRI, CT scan)
- Rationale for request of treatment
  - Treatment plan

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.
MN/IE

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>96446</td>
<td>Chemotherapy administration into the peritoneal cavity via indwelling port or catheter</td>
</tr>
<tr>
<td></td>
<td>96549</td>
<td>Unlisted chemotherapy procedure</td>
</tr>
<tr>
<td>HCPCS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Procedure</td>
<td>DWY38ZZ</td>
<td>Hyperthermia of Abdomen</td>
</tr>
<tr>
<td></td>
<td>DWY68ZZ</td>
<td>Hyperthermia of Pelvic Region</td>
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</tbody>
</table>

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>04/30/2015</td>
<td>BCBSA Medical Policy adoption</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>09/01/2016</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>09/01/2017</td>
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</tr>
<tr>
<td>11/01/2018</td>
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<td>Medical Policy Committee</td>
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<tr>
<td>12/01/2018</td>
<td>Policy title change from Cytoreductive Surgery and Perioperative Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>12/01/2019</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)
Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.