Subject: Plasma Exchange: Therapeutic Apheresis

Medical Policy #: 16.11

Original Effective Date: 09/25/2006

Status: Reviewed

Last Review Date: 11-16-2022

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Plasma exchange, also called plasmapheresis or apheresis, involves removal and replacement of the plasma component of blood. The goal of the procedure is to remove autoantibodies, cytokines or other plasma-soluble factors that are believed to contribute to the patient's symptoms.

Coverage Determination

Prior Authorization is not required. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

For Medicare, Medicaid, and Commercial.

Presbyterian follows National Coverage Determination (110.14) for Apheresis (Therapeutic Pheresis), for plasma exchange.

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

CPT Codes	Description
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion
36511	Therapeutic apheresis; for white blood cells
36512	Therapeutic apheresis; for red blood cells
36513	Therapeutic apheresis; for platelets
36514	Therapeutic apheresis; for plasma pheresis
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion
36522	Photopheresis, extracorporeal
P9052	Platelets, hla-matched leukocytes reduced, apheresis/pheresis, each unit
P9055	Platelets, leukocytes reduced, cmv-negative, apheresis/pheresis, each unit
P9073	Platelets, pheresis, pathogen-reduced, each unit
P9100	Pathogen(s) test for platelets
S2120	Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation

Reviewed by / Approval Signatures

Clinical Quality & Utilization Mgmt. Committee: Gray Clarke MD
Medical Director: David Yu MD
Medical Director: Ana Maria Rael MD
Date Approved: 11/16/2022

References

1. CMS, National Coverage Determination, (NCD) for Apheresis (Therapeutic Pheresis) (110.14), effective date of version #1: 07/30/1992. [Cited 10/24/202]
2. MCG Health, Ambulatory Care 26th Edition, Apheresis, Therapeutic, ACG: A-0173 (AC), Last update: 08-31-2022. [Cited 10/24/2022]

Publication History

05-25-16:	Annual Review. NCD 110.14 accessed. No changes in criteria. MCG A-0173 accessed. Last update 1/28/16. No changes in criteria.
09-27-17:	Annual Review. NCD 110.14 accessed. No changes in criteria. MCG A-0173 accessed. Last update 2/2/17. No changes in criteria.
07-31-19:	Annual Review. Previously titled Plasma Exchange for Multiple Sclerosis, Devic's Syndrome, Transverse Myelitis, and other conditions. since 10/03/2003. Split MPM 16.11 policy, one for Commercial/Medicaid (MPM 16.12) and this policy is for Medicare. NCD 110.14 remains unchanged.
11-18-20	Annual Review. Reviewed by PHP Medical Policy Committee on 10-28-2020. The related policy MPM 16.12 specific to Commercial and Medicaid has been retired. This policy will now cover for all LOB which will continue to follow NCD 110.14. Removed "for Medicare" from title. Prior authorization will now be required for codes: 0342T, 36511, 36512, 36513, 36514, 36516, 36522, P9052, P9055, P9073, P9100, S2120 for Medicare, Medicaid and Commercial.
11-17-21	Annual Review. Reviewed by PHP Medical Policy Committee on 10/27/2021. No change to criteria, policy will continue to follow NCD (110.14) Apheresis (Therapeutic Pheresis) for all product line. Prior authorization will be removed for 36511, 36512, 36513, 36514, 36516, 0342T, P9052, P9055, P9073, P9100 and S2120.
11-16-22	Annual Review. Reviewed by PHP Medical Policy Committee on 10/28/2022. No change to criteria, policy will continue to follow NCD (110.14) Apheresis (Therapeutic Pheresis) for all product line. Continue no prior authorization for CPT: 0342T, 36511, 36512, 36513, 36514, 36516, 36522 and HCPCS: P9052, P9055, P9073, P9100, S2120.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: ***Click here for Medical Policies***

Web links:

At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.