MEDICAL POLICY	Apheresis (Therapeutic Pheresis) (Medicare Only)
Effective Date: 10/1/2021  10/1/2021 Medical Officer Date	Medical Policy Number: 310 Medical Policy Committee Approved Date: 7/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Apheresis (Therapeutic Pheresis)	• National Coverage Determination (NCD) for Apheresis (Therapeutic Pheresis) (110.14)[1] • Local Coverage Article: Therapeutic Apheresis for Familial Hypercholesterolemia (A54543)[2]

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required Note: The following codes do not require prior authorization when billed at location code 21 (inpatient hospital).	
36514	Therapeutic apheresis; for plasma pheresis
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Apheresis (Therapeutic Pheresis) (110.14). https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=82. Published 1992. Accessed 5/10/21.
2. Centers for Medicare & Medicaid Services. Local Coverage Article: Therapeutic Apheresis for Familial Hypercholesterolemia (A54543). https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=54543. Published 2018. Accessed 5/10/21.