# Apheresis (Therapeutic Pheresis) (NCD 110.14)

**Guideline Number:** MPG016.02  
**Approval Date:** September 14, 2016

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructions for Use</td>
<td>1</td>
</tr>
<tr>
<td>Policy Summary</td>
<td>1</td>
</tr>
<tr>
<td>Applicable Codes</td>
<td>2</td>
</tr>
<tr>
<td>References</td>
<td>2</td>
</tr>
<tr>
<td>Guideline History/Revision Information</td>
<td>2</td>
</tr>
</tbody>
</table>

## Instructions for Use

This Policy Guideline is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates for health care services submitted on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450), or their electronic comparative. The information presented in this Policy Guideline is believed to be accurate and current as of the date of publication.

This Policy Guideline provides assistance in administering health benefits. All reviewers must first identify member eligibility, any federal or state regulatory requirements, Centers for Medicare and Medicaid Services (CMS) policy, the member specific benefit plan coverage, and individual provider contracts prior to use of this Policy Guideline. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document may differ greatly from the standard benefit plan upon which this Policy Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Policy Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

UnitedHealthcare follows Medicare coverage guidelines and regularly updates its Medicare Advantage Policy Guidelines to comply with changes in CMS policy. UnitedHealthcare encourages physicians and other healthcare professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other healthcare professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. This Policy Guideline is provided for informational purposes. It does not constitute medical advice.

## Policy Summary

**Overview**

Apheresis (also known as pheresis or therapeutic pheresis) is a medical procedure utilizing specialized equipment to remove selected blood constituents (plasma, leukocytes, platelets, or cells) from whole blood. The remainder is re-transfused into the person from whom the blood was taken.

**Guidelines**

For purposes of Medicare coverage, apheresis is defined as an autologous procedure, i.e., blood is taken from the patient, processed, and returned to the patient as part of a continuous procedure (as distinguished from the procedure in which a patient donates blood preoperatively and is transfused with the donated blood at a later date).

**Indications and Limitations of Coverage**

**Indications**

Apheresis is covered for the following indications:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom);
- Treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes;
- Plasmapheresis or plasma exchange as a last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease;
- Plasma exchange in the treatment of Goodpasture's Syndrome;
- Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for patients with severe or life threatening symptoms who have failed to respond to conventional therapy;
- Treatment of life threatening scleroderma and polymyositis when the patient is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome; and
- Treatment of last resort for life threatening systemic lupus erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration

**Settings**
Apheresis is covered only when performed in a hospital setting (either inpatient or outpatient) or in a nonhospital setting, e.g., a physician directed clinic when the following conditions are met:
- A physician (or a number of physicians) is present to perform medical services and to respond to medical emergencies at all times during patient care hours;
- Each patient is under the care of a physician; and
- All nonphysician services are furnished under the direct, personal supervision of a physician.

**APPLICABLE CODES**
The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36511</td>
<td>Therapeutic apheresis; for white blood cells</td>
</tr>
<tr>
<td>36512</td>
<td>Therapeutic apheresis; for red blood cells</td>
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<tr>
<td>36513</td>
<td>Therapeutic apheresis; for platelets</td>
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<tr>
<td>36514</td>
<td>Therapeutic apheresis; for plasma pheresis</td>
</tr>
</tbody>
</table>

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**REFERENCES**
CMS National Coverage Determinations (NCDs)
NCD 110.14 Apheresis (Therapeutic Pheresis)
Reference NCD: NCD 20.5 Extracorporeal Immunoabsorption (ECI) Using Protein A Columns

CMS Claims Processing Manual
Chapter 4; §231.9 Billing for Pheresis and Apheresis Services

UnitedHealthcare Commercial Policies
Apheresis

**GUIDELINE HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/14/2016</td>
<td>• Annual review</td>
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</table>