

## Extracorporeal Photopheresis

### MPM 5.7

<b>Disclaimer</b>	<b>Refer to the member's specific benefit plan and <i>Schedule of Benefits</i> 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.</b>
<b>Description</b>	<p>Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as ex vivo administration); after UVA light exposure, the treated white blood cells are then re-infused into the patient.</p> <p>The exact mechanism of action of extracorporeal photopheresis is still elusive. The role of UVA is to activate the normally inert 8-MOP. The activated 8-MOP molecules bind with the DNA of the white blood cells, which kills the cells. The dead white blood cells, once re-infused into the patient, stimulate the multiple different cells and proteins of the patient's immune system in a series of cascading reactions. This activation of the immune system then impacts the medical condition being treated; however, the precise manner in which the medical condition is affected is still largely unknown but is believed to vary by condition. Hence, extracorporeal photopheresis is a procedure that attempts to negatively impact the ability of specific immune cells to function but without inducing a general state of immunosuppression.<sup>1,2</sup></p> <p>For Photodynamic Therapy (PDT), see MPM 16.9.</p>
<b>Coverage Determination</b>	<p><b>Prior Authorization/Benefit Certification is not required; however, all claims are subject to retrospective review.</b></p> <p>Per CMS NCD 110.4, the extracorporeal photopheresis is approved in <b>any</b> of the following circumstances:</p> <ul style="list-style-type: none"><li>• Palliative treatment of skin manifestations of cutaneous T Cell lymphoma (e.g., mycosis fungoides, Sézary syndrome) that has not responded to other therapy; <b>or</b></li><li>• Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; <b>or</b></li><li>• Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.</li></ul>

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CMS NCD 110.4 is available at the following website address:

[http://www.cms.hhs.gov/mcd/viewncd.asp?ncd\\_id=110.4&ncd\\_version=2&basket=ncd%3A110%2E4%3A2%3AExtracorporeal+Photopheresis](http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=110.4&ncd_version=2&basket=ncd%3A110%2E4%3A2%3AExtracorporeal+Photopheresis)
**Exclusions**

All other indications for extracorporeal photopheresis are non-covered.

**Coding**
**The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.**

CPT Codes	Description
36522	Photopheresis, extracorporeal

ICD-9© Diagnosis Codes	Description
202.10-202.18	Mycosis fungoides
202.20-202.28	Sézary's disease
279.5	Graft-versus-host disease
279.50	Graft-versus-host disease, unspecified
279.52	Chronic graft-versus-host disease
279.3	Acute or chronic graft-versus-host disease
996.83	Complications of transplanted organ, heart
996.85	Bone marrow; complications of transplanted organ; graft-versus-host disease (acute) (chronic)
V42.1	Organ or tissue replaced by transplant; heart
V42.81	Organ or tissue replaced by transplant; bone marrow
V42.82	Organ or tissue replaced by transplant; peripheral stem cells

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- References:**
1. Centers for Medicare and Medicaid Services. NCD for Extracorporeal Photopheresis. Implementation date 04-02-07.
  2. Centers for Medicare and Medicaid Services. Decision Memo for Extracorporeal Photopheresis (CAG00324R). 12-19-06.

**Approval Signatures:** Clinical Quality Committee: Mark Whitaker MD

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03-25-09: Original effective date  
02-09-10: Coding update, no changes to coverage policy  
08-24-11: Annual Review

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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. This 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 on the Internet at <http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm>.

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Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and *Schedule of Benefits* to determine coverage.