Sentara Health Plans

Medicaid

Extracorporeal Photopheresis, Medical 237

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Effective Date	5/2008
Next Review Date	10/2025
Coverage Policy	Medical 237
Version	7

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity of Extracorporeal Photopheresis.

Description & Definitions:

Extracorporeal photopheresis is a nonsurgical procedure in which the individual's blood is drawn and white blood cells are separated and exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light.

Criteria:

Extracorporeal photopheresis is considered medically necessary with **1 or more** of the following:

- Individual has acute or chronic graft-versus-host disease when the disease is refractory to standard immunosuppressive drug treatment
- Individual requires palliative treatment of skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapies
- Individual has erythrodermic variants of cutaneous T cell lymphoma (e.g. Mycosis Fungoides/Sézary Syndrome (MF/SS), etc.)
- Individual has acute cardiac allograft rejection that is refractory to standard immunosuppressive drug treatment
- Individual with solid organ transplant rejection that is refractory to standard immunosuppressive drug treatment
- Individual has had a rejection of a lung transplant and **1 or more** of the following:
    - Individual is refractory to immunosuppressive drug treatment
    - Individual has a rapid decline in lung function

- Bronchiolitis obliterans syndrome (BOS)

Extracorporeal Photopheresis is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Atopic dermatitis
- Autoimmune diseases (e.g., multiple sclerosis, scleroderma, diabetes mellitus [DM] type 1, rheumatoid arthritis, systemic lupus erythematosus [SLE], psoriasis, and pemphigus)
- Crohn's disease
- Eosinophilic fasciitis
- Graft rejection in kidney transplant recipients
- Nephrogenic systemic fibrosis (previously known as nephrogenic fibrosing dermopathy)
- nephrogenic peritonitis

Coding:

Medically necessary with criteria:

Coding	Description
36522	Photopheresis, extracorporeal.

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: October
- 2021: December
- 2019: November
- 2016: January, February
- 2015: February, March
- 2014: January, November
- 2013: April, October
- 2012: September, October

Reviewed Dates:

- 2024: October – no changes references updated
- 2023: October
- 2020: December
- 2019: December
- 2018: August
- 2017: November
- 2012: April
- 2011: April
- 2010: April
- 2009: April

Effective Date:

- May 2008

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization

for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Endometrial Ablation, SHP Surgical 15, uterine bleeding, Menorrhagia, Hormonal therapy, Dilation and curettage, D&C, Pap smear, gynecologic examination, cervical disease, endometrial resection, electrosurgical ablation, thermoablation, hydrothermal endometrial ablation (HTEA), Thermal balloon endometrial ablation (TBEA), Microwave Endometrial Ablation (MEA), cryoablation, electrosurgical ablation, laser