DRAFT Local Coverage Determination (LCD) for Intravenous Immune Globulin (IVIG) (DL32712)

[PROPOSED/DRAFT]

Contractor Information

Contractor Name
Novitas Solutions, Inc.

Contractor Numbers
04911, 07101, 07102, 07201, 07202, 07301, 07302, 04111, 04112, 04211, 04212, 04311, 04312, 04411, 04412

Contractor Type
A and B MAC

Proposed/Draft LCD Information

Document Information

[PROPOSED/DRAFT]

Proposed LCD ID
DL32712

Proposed LCD Title
Intravenous Immune Globulin (IVIG)

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Jurisdictions

Arkansas, Louisiana, Mississippi, Colorado, Texas, Oklahoma, New Mexico

CMS National Coverage Policy
This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for IVIG services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for IVIG services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding IVIG services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
- Medicare Benefit Policy Manual – Pub. 100-02, Chapters 1 – Inpatient Hospital Services and 15 – Covered Medical and Other Health Services.
- Correct Coding Initiative – Medicare Contractor Beneficiary and Provider Communications Manual – Pub. 100-09, Chapter 5.

Coverage Guidance

Coverage Indications, Limitations and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

INDICATIONS:

The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immune globulin to those who lack it. Medicare will provide coverage for intravenous immune globulin when it is used in treatment of the following conditions:

- Primary immunodeficiency.
- Immune-mediated Thrombocytopenia (ITP).
- Kawasaki disease.
- Human Immunodeficiency Virus (HIV) (for pediatric use only).
- Bone marrow transplantation.
- Chronic B-cell lymphocytic leukemia.

Intravenous Immune Globulin (IVIG) can replace missing antibodies and decrease infection in primary immune deficiency and chronic lymphocytic leukemia, increase platelets in idiopathic thrombocytopenic purpura, prevent complications in Kawasaki disease and possibly decrease morbidity in some other conditions.

IVIG is the preferred treatment method for patients who require immediate increase in intravascular immunoglobulin antibody levels and are unable to produce sufficient amounts of Immunoglobulin G (IgG) antibodies. The therapeutic effect of IVIG is immediate, well tolerated and less likely to produce side effects if infused at the properly indicated rate(s). Sensitivity to these reactions is usually related to the infusion rate. Caution should be exercised in the administration of intravenous immune globulin; reactions may cause a rapid fall in blood pressure and clinical anaphylaxis.

IVIG is covered for treatment of the following biopsy-proven conditions:

- Pemphigus vulgaris.
- Pemphigus foliaceus.
- Bullous pemphigoid.
- Mucous membrane pemphigoid (aka, cicatricial pemphigoid), benign mucous membrane pemphigoid, with or without mention of ocular movement.
- Epidermolysis bullosa acquisita.

Patients must meet at least one of the following criteria:

- Failed conventional therapy. Contractors have the discretion to define what constitutes failure of conventional therapy.
- Conventional therapy is contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy.
- Have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents. In these situations, IVIG therapy would be given along with conventional treatment(s) and the IVIG would be used only until conventional therapy could take effect.

**Note:** In addition, IVIG for the treatment of autoimmune mucocutaneous blistering disease must be used only for short-term therapy and not as a maintenance therapy. *(From NCD 250.3)*

Other preparations of IVIG are available:

- RhoD immune globulin for use in preventing postpartum Rhesus isoimmunization.
- Cytomegalovirus immune globulin for use in treating or preventing cytomegaloviral disease in transplant recipients.
• Hepatitis B immune globulin intravenous for use in treating prevention of hepatitis B recurrence following liver transplantation in hepatitis B surface antigen (HBsAG)-positive liver transplant patients. (FDA approved April 6, 2007.)

Physicians should avoid prescribing IVIG except for patients with severe immune deficiency and who have low antibody levels or for those whom have other well-established indications for therapy with IVIG as described within this LCD.

**Primary Humoral Immunodeficiencies:**

IVIG will be covered for use as replacement therapy in patients with primary immunodeficiencies in whom severe impairment of antibody capacity is present in the following conditions:

- Congenital agammaglobulinemia.
- Common variable immunodeficiency.
- Wiskott-Aldrich syndrome
- X-linked immunodeficiency with hyper-IgM.
- Severe combined immunodeficiencies.
- Deficient qualitative and/or quantitative antibody production.
- Have at least one bacterial infection directly attributable to this deficiency.

**Idiopathic Thrombocytopenic Purpura (ITP):**

IVIG will be covered for both acute and chronic refractory ITP.

**Acute ITP, IVIG is covered for:**

- Management of acute bleeding due to severe thrombocytopenia (platelet counts usually less than 30,000/ul).
- To increase platelet counts prior to invasive surgical procedures, e.g. splenectomy.
- Severe thrombocytopenia (platelet counts less than 20,000/ul) considered to be at risk for intracerebral hemorrhage.

**Chronic refractory ITP is covered for patients meeting all of the following conditions:**

- Prior treatment with corticosteroids and splenectomy.
- Duration of illness of greater than six months.
- Age of 10 years or older.
- No concurrent illness/disease explaining thrombocytopenia.
- Platelet counts persistently at or below 20,000/ul.
Chronic Lymphocytic Leukemia (CLL):

IVIG will be covered when used to prevent recurrent bacterial infections in patients with B-cell chronic lymphocytic leukemia meeting all of the following conditions:

- Must have unequivocally documented CLL.
- An immunoglobulin G (IgG) level of less than 600 mg/dl.
- Recent history of serious bacterial infection(s) requiring either oral or parenteral antibiotic therapy.

Human Immunodeficiency Virus (HIV) Infection:

IVIG will be covered for patients infected with HIV to reduce significant bacterial infection meeting all of the following conditions:

- Age younger than 14 years old.
- Evidence of either qualitative or quantitative humoral immunologic defects.
- Current bacterial infections, despite appropriate antimicrobial prophylaxis.

Chronic Inflammatory Demyelinating Polyneuritis (CIDP):

The diagnosis of this condition must be documented in the medical record and must be consistent with published diagnostic criteria for this condition.


Patients responsive to an initial course of IVIG will be eligible for maintenance therapy coverage only if unequivocal neurological deterioration occurs at some future point in time. It is expected an initial trial of IVIG for CIDP to last 3 months. If no significant improvement as outlined in the above guidelines, therapy should be discontinued. Maintenance therapy should be at the lowest dose of IVIG possible. Although patients will vary in response, after a one to two year period of stable therapy, attempts to reduce should be occurring. Continued dosing without attempts to reduce the dosing and check responses would be considered inappropriate and subject to pre and post pay reviews.

Multifocal Motor Neuropathy:

IVIG may be considered for first line of treatment of patients who have progressive, symptomatic multifocal motor neuropathy that has been diagnosed on the basis of electrophysiology findings that rule out other possible conditions that may not respond to this treatment.

Dermatomyositis, Polymyositis:

The routine use of IVIG is not usually recommended for polymyositis or dermatomyositis. IVIG may be used in patients with severe active illness for whom other interventions have been unsuccessful, have become intolerable or are
Refractory myopathies are, by definition, diseases that are unresponsive or poorly responsive to high-dose steroids either alone or in combination with other immunsuppressive agents (azathioprine, cyclophosphamide, methotrexate). Also included in this definition are patients responsive to but intolerant of continual high-dose steroids as reflected by severe adverse side effects (e.g., steroids myopathy or severe osteoporosis) in whom trials of other immunosuppressive agents, unless contraindicated, have been unsuccessful in achieving significant long-term steroid dose reductions.

Three other coverage conditions which must all be met, in addition to the above, are:

- Biopsy-proven disease.
- At least a four- to six-month trial of prednisone or prednisone combination therapies.
- Lack of response/poor response to therapies as reflected by persistently elevated serum Creatine Kinase (CK) levels and/or lack of improvement on muscle strength improvement scales.

Inclusion body myositis - Please see limitation section below.

Use of IVIG in other specific situations:

Certain unusual uses of IVIG may be covered as described below: Please note - prepay determinations as well as postpay review may occur.

Autoimmune Hemolytic Anemia:

The routine use of IVIG is not usually recommended. IVIG may have a role in patients with warm-type autoimmune hemolytic anemia that does not respond to corticosteroids or splenectomy or those for whom the latter two treatments are contraindicated.

Multiple Sclerosis (MS):

The current evidence is inadequate to assess the value of IVIG in the treatment of multiple sclerosis. IVIG may be useful in persons as a second-line therapy in acute relapses of Relapsing Remitting Multiple Sclerosis (MS), but is generally not considered effective for maintenance therapy of MS or in slowing disease progression. LCD Individual Consideration may be given when IVIG is used in the treatment of an acute relapse of Relapsing Remitting MS.

Systemic Lupus Erythematosus:

The routine use of IVIG is not usually recommended. IVIG may be used in patients with severe active systemic lupus erythematosus for whom other interventions have been unsuccessful, have become intolerable or are contraindicated.

LIMITATIONS:

Immune Modulation prior to Transplantation

IVIG has not been proven safe and effective when used for immune modulation of highly sensitized patients prior to transplantation and is therefore not covered for this indication.
Inclusion body myositis is generally refractory to all therapies and its rate of progression appears to be unaltered by most therapies. IVIG will not be covered for use in patients with inclusion body myositis.

Drug Wastage

Please refer to Local Coverage Article Approved Drugs and Biologicals: Includes Cancer Chemotherapeutic Agents for guidance on drug wastage.

As published in CMS IOM 100-08, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient's medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient's medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.

Proposed/Draft Process Information

Associated Information

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

3. The submitted medical record must support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.

5. The information contained in the medical record should include all relevant diagnostic laboratory studies, prior history of bleeding, infection, disease progression, prior medical/surgical therapies and any other information essential in establishing that the patient meets the coverage indicators as set forth in this LCD.

6. An accurate weight in kilograms should be documented prior to the infusion since the dosage is based on mg/kg/dosage.

7. Indications for administration of IVIG therapy must be fully documented in the patient's medical record.

8. Physicians or other providers filing Medicare claims for administration of IVIG therapy at the request of another provider assume full responsibility as to the medical necessity for IVIG under terms and conditions of this LCD. These providers must also be able to meet documentation requirements given above, either directly through their own medical records or indirectly through records obtained from the referring physician.

9. Any amount wasted must be clearly documented in the medical record and should include the date and time, amount of medication wasted, and the reason for the wastage.

Appendices
N/A

Utilization Guidelines

Medicare would expect to see IVIG used only for the indications listed within this LCD.

**Notice:** This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient’s condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient’s medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

In accordance with CMS Ruling 95-1(V), utilization of these services should be consistent with locally acceptable standards of practice.

Sources of Information and Basis for Decision

**Contractor is not responsible for the continued viability of websites listed.**


Other Contractor Local Coverage Determinations

“Intravenous Immune Globulin (IVIG),” TrailBlazer Health Enterprises LCD, (00400) L17363, (00900) L22969.


“Immune Globulin, Intravenous,” Arkansas BlueCross BlueShield (Pinnacle) LCD, (NM, OK) L13458.

Novitas Solutions JL LCD L32937, Intravenous Immune Globulin (IVIG)

Novitas Solutions, Inc. - JH Local Coverage Determination (LCD) Consolidation Narrative Justification - Most Clinically Appropriate LCD

LCDs Compared:
L26774, Intravenous Immune Globulin (IVIG), TrailBlazer (A/B) - CO, NM, OK, TX
L31189, Immune Globulin, Intravenous (IVIG), PBSI (B) - AR, LA
L31097, Immune Globulin, Intravenous (IVIG), PBSI (A) - LA, MS
L31328, Immune Globulin, Intravenous (IVIG), PBSI (A) - AR
L30612, Immune Globulin, Intravenous (IVIG), Cahaba (B) - MS

CMD Rationale: All the above PBSI LCDs are identical.
First, using an assessment of whether apparent edits (including frequency limits) are more likely to promote clinically appropriate use of such LCD services, the following comparisons are noted:
TrailBlazer LCD #1 does a very good job with a special commendation for dual diagnosis coding, along with specifying individual consideration applications, along with key wastage requirements. PBSI LCDs #2-4 (duplicates) and Cahaba LCD #5 lack such detail.

Second, with respect to the text in the Indications... Section being well-correlated with those separately-listed procedure-to-diagnosis code pairings, the following findings are noted:

PBSI and TrailBlazer do the best job in a similar manner, with Cahaba being more minimalistic.

Third, none of the LCDs have literature-based summaries, such that this is not a discriminating factor between the three LCDs.

Fourth, all three LCDs are likely amenable to MR activities, but TrailBlazer and PBSI likely more helpful per more extensive clinical detail noted above.

Overall choice is TrailBlazer LCD #1, L26774, largely based upon the tiebreaker from the first discussion item. L26774 is the most clinically appropriate LCD.

Open Meetings/Part B MAC Contractor Advisory Committee (CAC) Meetings

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Meeting Type</th>
<th>Meeting State(s)</th>
<th>Meeting Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/29/2014</td>
<td>Open Meeting</td>
<td>Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas</td>
<td>The open meeting is a joint meeting for both JL and JH. The locations of the meeting are the PA Medical Society in Harrisburg, PA &amp; the Novitas Dallas office in Dallas, TX. The meeting in Dallas is limited to presenters only.</td>
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</tbody>
</table>

Comment Period Start Date

05/15/2014

Comment Period End Date

07/10/2014

Released to Final LCD Date

Not yet released.

Reason for Proposed LCD

Creation of Uniform LCDs With Other MAC Jurisdiction

Proposed LCD Contact

Donna Mandella
Suite 600
Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
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<tr>
<td>013x</td>
<td>Hospital Outpatient</td>
</tr>
<tr>
<td>021x</td>
<td>Skilled Nursing - Inpatient (Including Medicare Part A)</td>
</tr>
<tr>
<td>022x</td>
<td>Skilled Nursing - Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td>023x</td>
<td>Skilled Nursing - Outpatient</td>
</tr>
<tr>
<td>071x</td>
<td>Clinic - Rural Health</td>
</tr>
<tr>
<td>073x</td>
<td>Clinic - Freestanding</td>
</tr>
<tr>
<td>077x</td>
<td>Clinic - Federally Qualified Health Center (FQHC)</td>
</tr>
<tr>
<td>083x</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>085x</td>
<td>Critical Access Hospital</td>
</tr>
</tbody>
</table>

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.
**Note:** The contractor has identified Bill Type and Revenue Codes applicable for use with CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM) Pub. 100-04, Claims Processing Manual, for further guidance.

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<tr>
<td>0250</td>
<td>Pharmacy - General Classification</td>
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<tr>
<td>0636</td>
<td>Pharmacy - Drugs Requiring Detailed Coding</td>
</tr>
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</table>

**CPT/HCPCS Codes**

**Group 1 Paragraph: Note:** Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J0850</td>
<td>Cytomegalovirus imm IV /vial</td>
</tr>
<tr>
<td>J1459</td>
<td>Inj IVIG privigen 500 mg</td>
</tr>
<tr>
<td>J1556</td>
<td>Inj, imm glob bivigam, 500mg</td>
</tr>
<tr>
<td>J1557</td>
<td>Gammaplex injection</td>
</tr>
<tr>
<td>J1561</td>
<td>Gamunex-C/Gammaked</td>
</tr>
<tr>
<td>J1566</td>
<td>Immune globulin, powder</td>
</tr>
<tr>
<td>J1568</td>
<td>Octagam injection</td>
</tr>
<tr>
<td>J1569</td>
<td>Gammagard liquid injection</td>
</tr>
<tr>
<td>J1572</td>
<td>Flebogamma injection</td>
</tr>
<tr>
<td>J1573</td>
<td>Hepagam b intravenous, inj</td>
</tr>
<tr>
<td>J1599</td>
<td>IgG non-lyophilized, NOS</td>
</tr>
</tbody>
</table>
ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: Note: Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

The CPT/HCPCS codes included in this LCD will be subjected to “procedure to diagnosis” editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for CPT/HCPCS code **J0850**:

Covered for:

### Group 1 Codes:

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<th>Description</th>
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<tr>
<td>078.5</td>
<td>CYTOMEGALOVIRAL DISEASE</td>
</tr>
<tr>
<td>V42.0 - V42.7</td>
<td>KIDNEY REPLACED BY TRANSPLANT - LIVER REPLACED BY TRANSPLANT</td>
</tr>
<tr>
<td>V42.81 - V42.84</td>
<td>BONE MARROW REPLACED BY TRANSPLANT - ORGAN OR TISSUE REPLACED BY TRANSPLANT</td>
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<tr>
<td>V42.89</td>
<td>OTHER SPECIFIED ORGAN OR TISSUE REPLACED BY TRANSPLANT</td>
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</table>

**Group 1 Asterisk: N/A**

Group 2 Paragraph: Medicare is establishing the following limited coverage for CPT/HCPCS code **J1557** (when used to identify immune globulin Gammaplex®), **J1459, J1561** (when used to identify immune globulin Gamunex®/Gamunex-C®/Gammaked®), **J1556, J1566, J1568, J1569, J1572, and J1599**:

Covered for:
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>042*</td>
<td>HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE</td>
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<tr>
<td>078.5</td>
<td>CYTOMEGALOVIRAL DISEASE</td>
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<tr>
<td>204.10 -</td>
<td>CHRONIC LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION -</td>
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<tr>
<td>204.11</td>
<td>LYMPHOID LEUKEMIA CHRONIC IN REMISSION</td>
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<td>279.00</td>
<td>HYPOGAMMAGLOBULINEMIA UNSPECIFIED</td>
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<td>279.03 -</td>
<td>OTHER SELECTIVE IMMUNOGLOBULIN DEFICIENCIES - COMMON VARIABLE IMMUNODEFICIENCY</td>
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<td>OTHER DEFICIENCY OF HUMORAL IMMUNITY</td>
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<td>279.12</td>
<td>WISKOTT-ALDRICH SYNDROME</td>
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<td>COMBINED IMMUNITY DEFICIENCY</td>
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<td>DISEASE</td>
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<td>ACQUIRED HEMOLYTIC ANEMIA UNSPECIFIED</td>
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<td>CONSTITUTIONAL RED BLOOD CELL APLASIA</td>
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<td>286.4</td>
<td>VON WILLEBRAND'S DISEASE</td>
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<td>ACQUIRED HEMOPHILIA - ANTIPHOSPHOLIPID ANTIBODY WITH HEMORRHAGIC DISORDER</td>
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<td>OTHER HEMORRHAGIC DISORDER DUE TO INTRINSIC CIRCULATING ANTICOAGULANTS,</td>
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<td>287.33</td>
<td>THROMBOCYTOPENIC PURPURA</td>
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<td>333.91</td>
<td>STIFF-MAN SYNDROME</td>
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<td>356.4</td>
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<td>357.0</td>
<td>ACUTE INFECTIVE POLYNEURITIS</td>
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<td>357.81</td>
<td>CHRONIC INFLAMMATORY DEMYELINATING POLYNEURITIS - CRITICAL ILLNESS</td>
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<td>357.89</td>
<td>OTHER INFLAMMATORY AND TOXIC NEUROPATHY</td>
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<td>UNSPECIFIED INFLAMMATORY AND TOXIC NEUROPATHIES</td>
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<td>MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION - MYASTHENIA GRAVIS WITH (ACUTE) EXACERBATION</td>
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<td>358.1</td>
<td>MYASTHENIC SYNDROMES IN DISEASES CLASSIFIED ELSEWHERE</td>
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<td>LAMBERT-EATON SYNDROME, UNSPECIFIED - LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE</td>
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<td>358.31</td>
<td>LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE</td>
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<tr>
<td>358.39</td>
<td>LAMBERT-EATON SYNDROME IN OTHER DISEASES CLASSIFIED ELSEWHERE</td>
</tr>
<tr>
<td>446.1</td>
<td>ACUTE FEBRILE MUCOCUTANEOUS LYMPH NODE SYNDROME (MCLS)</td>
</tr>
<tr>
<td>656.10</td>
<td>RHEUS ISOIMMUNIZATION UNSPECIFIED AS TO EPISODE OF CARE IN PREGNANCY - RHEUS ISOIMMUNIZATION AFFECTING MANAGEMENT OF MOTHER DELIVERED</td>
</tr>
<tr>
<td>656.11</td>
<td>RHEUS ISOIMMUNIZATION AFFECTING MANAGEMENT OF MOTHER DELIVERED</td>
</tr>
<tr>
<td>656.13</td>
<td>RHEUS ISOIMMUNIZATION AFFECTING MANAGEMENT OF MOTHER ANTEPARTUM CONDITION</td>
</tr>
<tr>
<td>694.4</td>
<td>PEMPHIGUS - PEMPHIGOID</td>
</tr>
<tr>
<td>694.5</td>
<td>PEMPHIGUS - PEMPHIGOID</td>
</tr>
<tr>
<td>694.60</td>
<td>BENIGN MUCOUS MEMBRANE PEMPHIGOID WITHOUT OCULAR INVOLVEMENT - BENIGN MUCOUS MEMBRANE PEMPHIGOID WITH OCULAR INVOLVEMENT</td>
</tr>
<tr>
<td>694.61</td>
<td>BENIGN MUCOUS MEMBRANE PEMPHIGOID WITHOUT OCULAR INVOLVEMENT - BENIGN MUCOUS MEMBRANE PEMPHIGOID WITH OCULAR INVOLVEMENT</td>
</tr>
<tr>
<td>694.8</td>
<td>OTHER SPECIFIED BULLOUS DERMATOSES</td>
</tr>
<tr>
<td>710.3</td>
<td></td>
</tr>
</tbody>
</table>
**Group 2 Asterisk: **Note: Use 042 only for patients younger than 14 years of age. Use 357.9 for Multifocal Motor Neuropathy.

**Group 3 Paragraph:** Medicare is establishing the following limited coverage requirement for CPT/HCPCS code J1573:

**Covered for diagnosis code:**

**Group 3 Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V07.2*</td>
<td>NEED FOR PROPHYLACTIC IMMUNOTHERAPY</td>
</tr>
<tr>
<td>V42.7</td>
<td>LIVER REPLACED BY TRANSPLANT</td>
</tr>
</tbody>
</table>
**Group 3 Asterisk: Note:** One of the following diagnosis codes must be reported when V07.2 is reported on the claim.

**Group 4 Paragraph:** Secondary codes to be used with V07.2:

**Group 4 Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>070.20 - 070.23</td>
<td>VIRAL HEPATITIS B WITH HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - CHRONIC VIRAL HEPATITIS B WITH HEPATIC COMA WITH HEPATITIS DELTA</td>
</tr>
<tr>
<td>070.30 - 070.31</td>
<td>VIRAL HEPATITIS B WITHOUT HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - VIRAL HEPATITIS B WITHOUT HEPATIC COMA ACUTE OR UNSPECIFIED WITH HEPATITIS DELTA</td>
</tr>
</tbody>
</table>

**Group 4 Asterisk:** N/A

**Group 5 Paragraph:** Medicare is establishing the following limited coverage for CPT/HCPCS codes J2788, J2790 and J2792:

**Covered for:**

**Group 5 Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>287.31</td>
<td>IMMUNE THROMBOCYTOPENIC PURPURA</td>
</tr>
<tr>
<td>656.10 - 656.11</td>
<td>Rhesus isoimmunization unspecified as to episode of care in pregnancy - rhesus isoimmunization affecting management of mother delivered</td>
</tr>
<tr>
<td>656.13</td>
<td>Rhesus isoimmunization affecting management of mother antepartum condition</td>
</tr>
</tbody>
</table>

**Group 5 Asterisk:** N/A
ICD-9 Codes that DO NOT Support Medical Necessity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>359.71</td>
<td>INCLUSION BODY MYOSITIS</td>
</tr>
</tbody>
</table>

Associated Documents

Attachments

N/A

Related Local Coverage Documents

N/A

Related National Coverage Documents

N/A

Keywords

N/A