

# Local Coverage Article: Billing and Coding: Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home – Medicare Benefit Policy Manual, Chapter 15, 50.6 (A54660)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

## Article Information

### General Information

**Article ID**

A54660

**Original Effective Date**

10/01/2015

**Article Title**

Billing and Coding: Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home – Medicare Benefit Policy Manual, Chapter 15, 50.6

**Revision Effective Date**

08/13/2019

**Revision Ending Date**

N/A

**Article Type**

Billing and Coding

**Retirement Date**

N/A

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**CMS National Coverage Policy**

## Article Guidance

### Article Text:

This article describes CMS national coverage effective on/after January 1, 2004. Please see the Noridian Local Coverage Determination for additional indications at [www.noridianmedicare.com](http://www.noridianmedicare.com).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home if only an unspecified diagnosis is necessary). The Act defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. It is covered under this benefit when the patient has a diagnosed primary immune deficiency disease, it is administered in the home of a patient with a diagnosed primary immune deficiency disease, and the physician determines that administration of the derivative in the patient's home is medically appropriate. The benefit does not include coverage for items or services related to the administration of the derivative. For coverage of IVIG under this benefit, it is not necessary for the derivative to be administered through a piece of durable medical equipment.

## Coding Information

### CPT/HCPCS Codes

N/A

### CPT/HCPCS Modifiers

N/A

### ICD-10 Codes that Support Medical Necessity

#### Group 1 Paragraph:

The following ICD-10 diagnoses are covered per CMS Manual instructions noted above:

#### Group 1 Codes:

ICD-10 CODE	DESCRIPTION
D80.0	Hereditary hypogammaglobulinemia
D80.2	Selective deficiency of immunoglobulin A [IgA]
D80.3	Selective deficiency of immunoglobulin G [IgG] subclasses
D80.4	Selective deficiency of immunoglobulin M [IgM]
D80.5	Immunodeficiency with increased immunoglobulin M [IgM]
D80.6	Antibody deficiency with near-normal immunoglobulins or with

ICD-10 CODE	DESCRIPTION
	hyperimmunoglobulinemia
D80.7	Transient hypogammaglobulinemia of infancy
D81.0	Severe combined immunodeficiency [SCID] with reticular dysgenesis
D81.1	Severe combined immunodeficiency [SCID] with low T- and B-cell numbers
D81.2	Severe combined immunodeficiency [SCID] with low or normal B-cell numbers
D81.5	Purine nucleoside phosphorylase [PNP] deficiency
D81.6	Major histocompatibility complex class I deficiency
D81.7	Major histocompatibility complex class II deficiency
D81.89	Other combined immunodeficiencies
D81.9	Combined immunodeficiency, unspecified
D82.0	Wiskott-Aldrich syndrome
D82.1	Di George's syndrome
D82.4	Hyperimmunoglobulin E [IgE] syndrome
D83.0	Common variable immunodeficiency with predominant abnormalities of B-cell numbers and function
D83.1	Common variable immunodeficiency with predominant immunoregulatory T-cell disorders
D83.2	Common variable immunodeficiency with autoantibodies to B- or T-cells
D83.8	Other common variable immunodeficiencies
D83.9	Common variable immunodeficiency, unspecified
G11.3	Cerebellar ataxia with defective DNA repair

### ICD-10 Codes that DO NOT Support Medical Necessity

N/A

### Additional ICD-10 Information

N/A

### 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.

N/A

**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.

N/A

**Other Coding Information**

N/A

## Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
08/13/2019	R3	As required by CR 10901, article is converted to a formal billing and coding type article. There is no change in coverage.
08/13/2019	R2	Article is revised to add the following diagnoses, per CR 11295: D80.2, D80.3, D80.4, D80.6, D80.7, D81.5, D82.1, D82.4, D83.1 and G11.3.
04/12/2018	R1	This article effective 4/12/2018, combines JEA A54658 in JEB A54660 so that both JEA and JEB Contract numbers will have the same final MCD Article number A54660.

## Associated Documents

**Related Local Coverage Document(s)**

LCD(s)

L34314 - Immune Globulin Intravenous (IVIg)

**Related National Coverage Document(s)**

N/A

**Statutory Requirements URL(s)**

N/A

**Rules and Regulations URL(s)**

N/A

**CMS Manual Explanations URL(s)**

Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

**Other URL(s)**

N/A

**Public Version(s)**

Updated on 05/07/2020 with effective dates 08/13/2019 - N/A

Updated on 07/18/2019 with effective dates 08/13/2019 - N/A

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Updated on 09/04/2015 with effective dates 10/01/2015 - N/A

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## Keywords

N/A