

Local Coverage Article: Billing and Coding: Immune Globulin Intravenous (IVIg) (A57187)

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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

A57187

Article Title

Billing and Coding: Immune Globulin Intravenous (IVIg)

Article Type

Billing and Coding

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N/A

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N/A

or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com.

CMS National Coverage Policy

Title XVIII of the Social Security Act; Section 1862(a)(1)(A) section allows coverage and payment for only those services that are considered to be reasonable and necessary.

Title XVIII of the Social Security Act; Section 1833(e). This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

CMS Manual, Pub.100-2, Chapter 15, section 50.4 and section 50.4.2. This section addresses coverage of drugs and biologicals.

CMS Manual, Pub.100-3, Chapter 1, Section 250.3. This section describes coverage for IVIg for treatment of Autoimmune Mucocutaneous Blistering Diseases.

"Intravenous immune globulin (IVIg) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents.

Effective October 1, 2002, IVIg is covered for the treatment of biopsy-proven: (1) Pemphigus Vulgaris, (2) Pemphigus Foliaceus, (3) Bullous Pemphigoid, (4) Mucous Membrane Pemphigoid (a.k.a., Cicatricial Pemphigoid), and (5) Epidermolysis Bullosa Acquisita for the following patient subpopulations:

- Patients who have failed conventional therapy. Contractors have the discretion to define what constitutes failure of conventional therapy;*
- Patients in whom conventional therapy is otherwise contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy; or*
- Patients with rapidly progressive disease in whom a clinical response could not be affected quickly enough using conventional agents. In such situations IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until the conventional therapy could take effect.*

In addition, IVIg for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short-term therapy and not as a maintenance therapy. Contractors have the discretion to decide what constitutes short-term therapy."

See associated article for ICD-10 diagnosis codes.

CMS Manual, Pub. 100-2, Chapter 15, Section 50.6. This section describes coverage of IVIg for the treatment of Primary Autoimmune Deficiency Disease in the home.

"Beginning for dates of service on or after January 1, 2004, 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 (ICD-10 diagnosis codes D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9 and G11.3) in the home. 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."

See associated article for ICD-10 diagnosis codes.

Article Guidance

Article Text:

The following billing coding and guidance is to be used with its associated Local Coverage Determination.

Medical record documentation maintained by the treating physician must clearly document the medical necessity to initiate IVIg therapy and the continued need thereof. Required documentation of medical necessity could include:

- History and physical;
- Office/progress note(s);
- Test results with written interpretation; and An accurate weight in kilograms should be documented prior to the infusion since the dosage is based mg/kg/dosage.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
J1459	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
J1556	INJECTION, IMMUNE GLOBULIN (BIVIGAM), 500 MG
J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G., LIQUID), 500 MG
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), NOT OTHERWISE SPECIFIED, 500 MG
J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG

CODE	DESCRIPTION
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E.G., LIQUID), 500 MG
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), NOT OTHERWISE SPECIFIED, 500 MG

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

N/A

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
B20*	Human immunodeficiency virus [HIV] disease
B25.0	Cytomegaloviral pneumonitis
B25.1	Cytomegaloviral hepatitis
B25.2	Cytomegaloviral pancreatitis
B25.8	Other cytomegaloviral diseases
C90.00	Multiple myeloma not having achieved remission
C90.02	Multiple myeloma in relapse
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.11	Chronic lymphocytic leukemia of B-cell type in remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
D59.0	Drug-induced autoimmune hemolytic anemia
D59.11	Warm autoimmune hemolytic anemia
D59.12	Cold autoimmune hemolytic anemia
D59.13	Mixed type autoimmune hemolytic anemia
D59.19	Other autoimmune hemolytic anemia
D61.01*	Constitutional (pure) red blood cell aplasia
D69.3	Immune thrombocytopenic purpura
D69.42	Congenital and hereditary thrombocytopenia purpura

ICD-10 CODE	DESCRIPTION
D69.49	Other primary thrombocytopenia
D80.0	Hereditary hypogammaglobulinemia
D80.1	Nonfamilial 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 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
G25.82	Stiff-man syndrome
G35	Multiple sclerosis
G60.3	Idiopathic progressive neuropathy
G61.0	Guillain-Barre syndrome

ICD-10 CODE	DESCRIPTION
G61.81*	Chronic inflammatory demyelinating polyneuritis
G61.82	Multifocal motor neuropathy
G65.0	Sequelae of Guillain-Barre syndrome
G70.00	Myasthenia gravis without (acute) exacerbation
G70.01	Myasthenia gravis with (acute) exacerbation
G70.81	Lambert-Eaton syndrome in disease classified elsewhere
G73.1	Lambert-Eaton syndrome in neoplastic disease
G73.3	Myasthenic syndromes in other diseases classified elsewhere
I78.8*	Other diseases of capillaries
M30.3	Mucocutaneous lymph node syndrome [Kawasaki]
M31.1	Thrombotic microangiopathy
M33.00	Juvenile dermatomyositis, organ involvement unspecified
M33.01	Juvenile dermatomyositis with respiratory involvement
M33.02	Juvenile dermatomyositis with myopathy
M33.09	Juvenile dermatomyositis with other organ involvement
M33.10	Other dermatomyositis, organ involvement unspecified
M33.11	Other dermatomyositis with respiratory involvement
M33.12	Other dermatomyositis with myopathy
M33.19	Other dermatomyositis with other organ involvement
M33.20	Polymyositis, organ involvement unspecified
M33.21	Polymyositis with respiratory involvement
M33.22	Polymyositis with myopathy
M33.29	Polymyositis with other organ involvement
M33.90	Dermatopolymyositis, unspecified, organ involvement unspecified
M33.91	Dermatopolymyositis, unspecified with respiratory involvement
M33.92	Dermatopolymyositis, unspecified with myopathy
M33.99	Dermatopolymyositis, unspecified with other organ involvement
M34.83	Systemic sclerosis with polyneuropathy
M36.0	Dermato(poly)myositis in neoplastic disease
T86.01	Bone marrow transplant rejection
T86.02	Bone marrow transplant failure
T86.09	Other complications of bone marrow transplant

ICD-10 CODE	DESCRIPTION
T86.11	Kidney transplant rejection
T86.12	Kidney transplant failure
T86.19	Other complication of kidney transplant
T86.21	Heart transplant rejection
T86.22	Heart transplant failure
T86.298	Other complications of heart transplant
T86.5	Complications of stem cell transplant
Z48.21	Encounter for aftercare following heart transplant
Z48.22	Encounter for aftercare following kidney transplant
Z76.82	Awaiting organ transplant status
Z86.19	Personal history of other infectious and parasitic diseases
Z87.01	Personal history of pneumonia (recurrent)
Z94.0	Kidney transplant status
Z94.1	Heart transplant status
Z94.81	Bone marrow transplant status
Z94.84	Stem cells transplant status

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:

*B20 is only payable for children under 13 years of age.

*D61.01 is only to be used when patient has failed all first line therapies.

*G61.81 is not payable when associated with diabetes mellitus, dysproteinemias, renal failure, or malnutrition.

*I78.8 - use only for Idiopathic Systemic Capillary Leak Syndrome (Clarkson's disease).

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Any diagnosis codes other than those listed in the covered ICD-10-CM codes of this policy and those in the attached article will be denied as not reasonable and necessary and will be denied provider liable unless a non-coverage notice has been issued to the beneficiary prior to the test. Screening diagnoses will be denied as routine services.

Group 1 Codes:

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.

CODE	DESCRIPTION
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
085x	Critical Access Hospital

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.

CODE	DESCRIPTION
0636	Pharmacy - Drugs Requiring Detailed Coding

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/01/2020	R2	10/1/2020: DX D59.1 was deleted from Group 1 under "ICD-10 Codes that Support Medical Necessity." D59.11; D59.12; D59.13; D59.19 were added to Group 1 under "ICD-10 Codes that Support Medical Necessity."

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		These revisions are due to the Annual ICD-10 Updates effective 10/01/2020.
02/01/2020	R1	ICD-10 code I78.8 is added with clarification for its use.

Associated Documents

Related Local Coverage Document(s)

Article(s)

A54660 - 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

A54641 - Billing and Coding: Intravenous Immune Globulin (IVIg)-NCD 250.3

A54645 - Response to Comments: Immune Globulin Intravenous (IVIg)

LCD(s)

L34314 - Immune Globulin Intravenous (IVIg)

Related National Coverage Document(s)

NCD(s)

250.3 - Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

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