Immunoglobulin Therapy (Intravenous and Subcutaneous) in the HOME

Origination:       June 17, 2009
Review Date:      November 18, 2015
Next Review:     November, 2017

DESCRIPTION OF PROCEDURE OR SERVICE
Intravenous Immunoglobulin (IVIG) is a solution of human immunoglobulins specifically prepared for intravenous infusion for the treatment of primary immune deficiency disease. It is considered medically necessary for use as replacement therapy in patients with primary immunodeficiency in which severe impairment of antibody capacity is present. Covered diseases include congenital hypogammaglobulinemia, common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked immunodeficiency with hyper-IgM, chronic inflammatory demyelinating polyneuropathy, and severe combined immunodeficiency.

POLICY STATEMENT
Coverage will be provided for IVIG when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION
Please refer to the member’s individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations if the criteria are met.

Coverage decisions for will be made in accordance with:
- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member’s particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.
INDICATIONS FOR COVERAGE

PART B COVERAGE CRITERIA:
A. Preauthorization by the Plan may be required;

1. Intravenous immune globulin (IVIG) is covered if all of the following criteria are met:
   a. It is an approved pooled plasma derivative for the treatment of primary immune deficiency disease; and
   b. The member has a diagnosis of primary immune deficiency disease (D80.0), (D80.5), (D81.0; D81.1; D81.2; D81.6, D81.7, D81.89; D81.9), (D82.0), (D83.0, D83.2, D83.8, D83.9); and
   c. The IVIG is administered in the home; and
   d. The treating physician has determined that administration of the IVIG in the patient’s home is medically appropriate; and
   e. The IVIG is administered with an infusion pump.

2. Subcutaneous immune globulin is covered only if criteria a and b are met:
   a. The subcutaneous immune globulin preparation is a pooled plasma derivative which is approved for the treatment of primary immune deficiency disease; and
   b. The member has a diagnosis of primary immune deficiency disease.

WHEN COVERAGE WILL NOT BE APPROVED UNDER PART B BENEFIT
When all of the criteria noted above are not met.

Codes J1573 (hepatitis B immune globulin, Hepagam B) and J2791 (Rho (D) immune globulin, Rhophylac) are non-covered under Part B. These drugs are not indicated for the treatment of primary immune deficiency disease (Part B #1b above).

PART D COVERAGE CRITERIA:
Preauthorization by the Plan is required;
1. If the above criteria are not met for coverage under the Part B benefit, the medication may be covered under Part D if:
   a. The medication is administered for an FDA approved use;
   b. The medication is on a prescription from a physician;
   c. The medication is used and sold in the United States;
   d. The medication is used for a medically accepted indication and is not for the diagnosis of primary immune deficiency disease as listed above.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION
This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable Codes: J1459, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1579, J1599.
The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**SPECIAL NOTES**

1. IVIG may be covered under Part B if the criteria in the LCD are met and if no infusion pump is used.

**References:**

1. Medicare Local Coverage Determination for Intravenous Immunoglobulin (IVIG) – CGS Administrators (L33610); Effective date: 10/01/2015; Accessed via [www.cms.gov](http://www.cms.gov); 10/15/2015.
2. Medicare Claims Processing Manual, Chapter 17, Section 80.6; Accessed via Internet site [www.cms.gov](http://www.cms.gov); viewed on 8/13/2013; Section 50.3 and Section 60.1 assessed online on 11/12/2013.

**Policy Implementation/Update Information:**

Revision Date: New policy June 17, 2009, Reviewed March 2010-Formatting and minor wording changes. August 2012-no criteria changes, updated applicable codes.

Revision Date: Revised December 18, 2013. Policy edited to include coverage for IVIG under Part B if it meets the local jurisdiction criteria.

Revision Date: April 16, 2014 updated code.

Revision Date: November 18, 2015. Annual Review, updated title to reflect addition of subcutaneous immune globulin criteria added to the policy. Updated Description of Procedure or Service per CMS guidance; Indications For Coverage: removed ICD-9 diagnosis codes for item #1 and added item #2 coverage criteria for Subcutaneous Immune Globulin for policy consistency and clarity; added subcutaneous immune globulin codes to Code section; updated reference section. 12/16/15 Added code J1579.

**Approval Dates:**

Medical Coverage Policy Committee: November 18, 2015

Policy Owner: Jennifer Davis, RN, MHA
Medical Policy Coordinator