Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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Benefit Information

Category: Surgery

Title: Transfusion Therapy for Hemolytic Disease of the Fetus and Newborn

Procedure Code(s): 36430

Description / Background

Transfusion therapy for fetal and neonatal disease can involve either a simple transfusion or an exchange transfusion. In neonates an exchange transfusion is the method used, while in fetuses either a simple transfusion or an exchange transfusion may be used.

One of three types of intrauterine transfusion techniques may be used:

- Intraperitoneal intrauterine fetal transfusion,
- Direct intrauterine transfusion (via umbilical artery/vein) without exchange of donor blood for fetal blood, or
- Intrauterine exchange transfusion (via umbilical artery/vein).

CPT / HCPCS Level II Codes and Description

36430	Transfusion of blood or blood components
36440	Push transfusion, blood, 2 years or under
36450	Exchange transfusion, blood; newborn
36460	Transfusion, intrauterine, fetal
36510	Catheterization of umbilical vein for diagnosis or therapy, newborn
36660	Catheterization, umbilical artery, newborn, for diagnosis or therapy
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation

Diagnoses / Medical Conditions

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- Erythroblastosis
- Hydrops fetalis
- ABO incompatibility
- Rh incompatibility
- Hemolytic anemia
- Hyperbilirubinemia

Medical Policy Statement

The safety and effectiveness of transfusion therapy have been established. It may be considered a useful therapeutic option when indicated.

Rationale

Hemolytic disease of the newborn (HDN) occurs due to maternal IgG antibodies crossing the placenta producing hemolysis primarily due to Rh, ABO and Kell group incompatibility. A systematic approach to the Rh HDN involves an obstetric history of a previously isoimmunized baby, timing and regular monitoring of maternal Rh antibodies and pigment assay of amniotic fluid. Timely decision regarding in utero transfusion based on maternal monitoring has improved outcomes.

The evaluation and management of obstetric patients with Rh isoimmunization has been studied extensively, with a general overall treatment plan consensus. Some differences in management, including the timing of initiation of amniocentesis for amniotic fluid measurements and fetal evaluation by ultrasonography, remain controversial.

If there are sonographic signs of fetal deterioration (ascites, effusions, hydrops) or a significant rise in the amniotic fluid $DeltaOD_{450}$ level, cordocenteis with fetal transfusion is recommended. It is also recommended that a modified biophysical profile be performed twice weekly to follow the amniotic fluid volume and fetal status.

Medical Policy Position Summary (Non-clinical summary statement for customer use)

The safety and effectiveness of transfusion therapy have been established. It may be considered a useful therapeutic option when indicated.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions

N/A

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Hyperlink (Audit criteria)

Related Policies

N/A

Hyperlink

Medicare Information

No National or Local Medicare policy is available.

(The above Medicare information is current as of the review date for this policy. However, since Medicare coverage issues and policies may be updated or revised by Centers for Medicare & Medicare Services (CMS, formerly HCFA) on a frequent basis, the most current information may not be contained in this document. For the most current information, you should contact an official source.)

References

- Blue Cross Blue Shield Association, "Transfusion Therapy for Hemolytic Disease of the Fetus and the Newborn," *Medical Policy Reference Manual,* Policy #4.01.06, original policy date March 31, 1996.
- Farrant, B., et al., "Outcome of infants receiving in-utero transfusions for haemolytic disease," *New Zealand Medical Journal*, September 14, 2001, Vol. 114.No. 139, pp. 400-3.
- Narang, A., et al., "Haemolytic disease of newborn," *Indian Journal of Pediatrics*, February 1, 2001, Vol. 68, No. 2, pp.167-72.
- Ogburn, Paul L., MD, et al., "In utero erythrocyte transfusion for fetal xerocytosis associated with severe anemia and non-immune hydrops fetalis," *American Journal of Obstetrics and Gynecology*, July 2001, Vol. 185, No. 1, pp, 238-9.
- Overton, MD, Mrcog, Timothy G., et al., "Serial aggressive platelet transfusion for fetal alloimmune thromocytopenia: Platelet dynamics and perinatal outcome," *American Journal of Obstetrics and Gynecology*, April 2002, Vol. 186, No. 4, pp. 826-31.
- Poland, Ronald L., MD, "Preventing kernicterus: Almost there," *Journal of Pediatrics*, Vol.140, No. 4, pp. 385-6.
- Spong, Catherine Y., MD, et al., "Management of isoimmunization in the presence of multiple maternal antibodies," *American Journal of Obstetrics and Gynecology*, August 2001, Vol. 185, No. 2, pp. 481-4.

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Joint BCBSM/BCN Medical Policy History

Date	Rationale
6/27/02	Joint policy established
11/18/03	See comment below

Next Review: This policy is established and is no longer subject to periodic review.

Pre-Consolidation Medical Policy History

Original Policy Date		Comments
BCN	N/A	Revised: N/A
BCBSM	10/24/96	Revised: N/A

Hyperlink Secured for internal use only (Internal information, e.g., Medical Policy Committee minutes, etc.)

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BLUE CARE NETWORK
POLICY: TRANSFUSION THERAPY FOR HEMOLYTIC DISEASE

I. Coverage Determination:

Transfusion therapy is a covered benefit for the treatment of the following diseases of the fetus and the newborn:

- Erythroblastosis
- Hydrops fetalis
- ABO incompatibility
- Rh incompatibility
- Hemolytic anemia
- Hyperbilirubinemia

Transfusion therapy for children, adolescents and adults may also be appropriate in other conditions.

II. Benefit Information:

Appropriate hospital copayments will apply:

- BCN 1, BCN 5, BCN 5 Michigan Catholic Conference, FEP – no copayment
- BCN 10, BCN Non-Group, Personal Plus – The hospital copayment is 25% of all hospital-billed fees for facility, professional and related services received while an inpatient and for outpatient surgery. All copayments made for hospital-billed fees apply to a hospital copayment maximum. Once the maximum is reached, no copays will be taken for hospital-billed services for the rest of the year.
- BCN Basic – All hospital inpatient and outpatient services are subject to a 20% copayment. Where more than one service is provided at one time, all the applicable copayments apply. Certain copayments will accumulate toward an annual copayment. Once the annual copayment maximum is reached in any calendar year, the copayments for benefits that are described as applicable toward the annual copayment maximum are waived.

Requires plan approval with clinical review? ☐ Yes ☒ No ☐ N/A (Not covered)

III. Benefit Exclusions:

N/A

IV. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP.
- Services must be performed by a BCN-contracted provider, if available.
- Appropriate copayments will apply.

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- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- Payment is based on BCN payment rules, individual certificate benefits, and certificate riders.
- Duplicate (back-up) equipment is not a covered benefit.

V. Effective Date:

Policy taken off routine review schedule: 11/18/03
Joint policy effective date: 6/27/02
Supersedes benefit information of: N/A

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