ICD-10 Codes for Next-Generation Sequencing Lab-Developed Tests (Myeloid Malignancies and Suspected Myeloid Malignancies)

Many applications of the molecular pathology procedures are not covered services given a lack of benefit category (e.g., preventive service or screening for a genetic abnormality in the absence of a suspicion of disease) and/or failure to meet the reasonable and necessary threshold for coverage (e.g., based on quality of clinical evidence and strength of recommendation or when the results would not reasonably be used in the management of a beneficiary). Furthermore, payment of claims in the past (based on "stacking" codes) or in the future (based on the new code series) is not a statement of coverage since the service may not have been audited for compliance with program requirements and documentation supporting the reasonable and necessary testing for the beneficiary. Certain molecular pathology procedures may be subject to medical review (medical records requested). The medical records must support the service billed.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made 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 (NPP) responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. In accordance with CFR Section 410.32, the medical record must contain documentation that the testing is expected to influence treatment of the condition toward which the testing is directed and will be used in the management of the beneficiary's specific medical problem.
5. The medical record must support that the referring/ordering practitioner who ordered the test for a specific medical problem is treating the beneficiary for this specific medical problem. An example of documentation that could support the practitioner's management of the beneficiary's specific medical problem would be at least two E/M visits performed by the ordering/referring practitioner over the previous six months.
6. The medical record must include documentation of how the ordering/referring practitioner used the test results in the management of the beneficiary's specific medical problem.
7. The ordering physician/NPP documentation in the medical record must include, but is not limited to, history and physical or exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing, imaging results).
8. The medical record from the ordering physician/NPP must clearly indicate all tests that are to be performed.
9. Documentation requirements of the performing laboratory (when requested) include, but are not limited to, lab accreditation, test requisition, test record/procedures, reports (preliminary and final), and quality control record.

The following types of tests are examples of services that are not relevant to a Medicare beneficiary, are not considered a Medicare benefit (statutorily excluded), and therefore will be denied as Medicare Excluded Tests:

- Tests considered screening in the absence of clinical signs and symptoms of disease that are not specifically identified by the law
- Tests performed to determine carrier screening
- Tests performed for screening hereditary cancer syndromes
- Prenatal diagnostic testing
- Tests performed on patients without signs or symptoms to determine risk for developing a disease or condition
- Tests performed to measure the quality of a process
- Tests without diagnosis specific indications
- Tests identified as investigational by available literature and/or the literature supplied by the developer and are not a part of a clinical trial

Screening services such as pre-symptomatic genetic tests and services used to detect an undiagnosed disease or disease predisposition are not a Medicare benefit and are not covered.

ICD-10 Codes for Next-Generation Sequencing Lab-Developed Tests (Myeloid Malignancies and Suspected Myeloid Malignancies)

In accordance with the Code of Federal Regulations, Title 42, Subchapter B, Part 410, Section 410.32, the referring/ordering practitioner must have an established relationship with the patient, and the test results must be used by the ordering/referring practitioner in the management of the patient's specific medical problem

Medicare has limited coverage policies for certain laboratory tests. Tests subject to a limited coverage policy must meet medical-necessity criteria in order to be covered by Medicare. Tests ordered without a supportive ICD-10 code will not satisfy medical necessity and therefore will not be covered by Medicare. For NGS (Next-Generation Sequencing) molecular testing for non-solid tumors, like hematological malignancies, see the associated lists of common ICD 10 codes that are part of a limited coverage policy that may support medical necessity.

Complete the 5-digit codes with a 5th digit

Not having achieved remission	0
In remission	1
In relapse	2

Group 1 Codes to Complete

Acute myeloblastic leukemia	C92.0_
Chronic myeloid leukemia, BCR/ABL-positive	C92.1_
Atypical chronic myeloid leukemia, BCR/ABL-negative	C92.2_
Myeloid sarcoma	C92.3_
Acute promyelocytic leukemia	C92.4_
Acute myelomonocytic leukemia	C92.5_
Acute myeloid leukemia with 11q23-abnormality	C92.6_
Acute myeloid leukemia with multilineage dysplasia	C92.A_
Other myeloid leukemia	C92.Z_
Myeloid leukemia	C92.9_
Acute monoblastic/monocytic leukemia	C93.0_
Acute erythroid leukemia	C94.0_
Acute panmyelosis with myelofibrosis	C94.4_
Acute erythroid leukemia	C94.0_

Group 1 Codes

Chronic myelomonocytic leukemia, not having achieved remission	C93.10
Chronic myelomonocytic leukemia, in relapse	C93.12
Other monocytic leukemia, not having achieved remission	C93.Z0
Other monocytic leukemia, in relapse	C93.Z2
Monocytic leukemia, not having achieved remission	C93.90
Monocytic leukemia, unspecified in relapse	C93.92
Acute megakaryoblastic leukemia, in remission	C94.21
Myelodysplastic disease, not elsewhere classified	C94.6
Polycythemia vera	D45
Refractory anemia without ring sideroblasts, so stated	D46.0
Refractory anemia with ring sideroblasts	D46.1
Refractory anemia with excess of blasts, unspecified	D46.20
Refractory anemia with excess of blasts 1	D46.21
Refractory anemia with excess of blasts 2	D46.22
Refractory cytopenia with multilineage dysplasia	D46.A
Refractory cytopenia with multilineage dysplasia and ring sideroblasts	D46.B
Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	D46.C
Refractory anemia, unspecified	D46.4
Other myelodysplastic syndromes	D46.Z
Myelodysplastic syndrome, unspecified	D46.9
Systemic mastocytosis	D47.02
Chronic myeloproliferative disease	D47.1
Essential (hemorrhagic) thrombocythemia	D47.3
Osteomyelofibrosis	D47.4
Other specified neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue	D47.Z9
Fanconi anemia	D61.03
Other constitutional aplastic anemia	D61.09
Idiopathic aplastic anemia	D61.3
Other pancytopenia	D61.818
Other specified aplastic anemias and other bone marrow failure syndromes	D61.89
Aplastic anemia, unspecified	D61.9
Anemia, unspecified	D64.9
Other primary thrombocytopenia	D69.49
Other secondary thrombocytopenia	D69.59
Thrombocytopenia, unspecified	D69.6
Other specified hemorrhagic conditions	D69.8
Cyclic neutropenia	D70.4
Other neutropenia	D70.8
Other decreased white blood cell count	D72.818
Lymphocytosis (symptomatic)	D72.820
Monocytosis (symptomatic)	D72.821
Elevated white blood cell count, unspecified	D72.829
Secondary polycythemia	D75.1
Myelofibrosis	D75.81
Congenital cutaneous mastocytosis	Q82.2
Splenomegaly, not elsewhere classified	R16.1
Hepatomegaly with splenomegaly, not elsewhere classified	R16.2

***Additional codes may be needed for billing purposes. Call us at 1.877.617.4445 if you have any questions.**
This list is subject to change and is not all-inclusive.

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Please refer to the most current version of the **Coding Manual of the American Medical Association (AMA)** for a complete list of ICD-10 codes. Information has been obtained through the **Centers for Medicare and Medicaid Services (CMS)** and Local Coverage Determination for Flow Cytometry. Codes listed are effective as of October 1, 2024.