Clinical Policy Title: Treatments of Hyperemesis Gravidarum

Clinical Policy Number: 12.02.02

Policy contains:
- Ondansetron (Zofran) subcutaneous pump.
- Intravenous hydration.
- Hyperemesis gravidarum treatment.

Related policies: None

ABOUT THIS POLICY: Arbor Health Plan has developed clinical policies to assist with making coverage determinations. Arbor Health Plan's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Arbor Health Plan when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Arbor Health Plan's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Arbor Health Plan's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Arbor Health Plan will update its clinical policies as necessary. Arbor Health Plan's clinical policies are not guarantees of payment.

Coverage Policy

I. Arbor Health Plan considers the use of Zofran via subcutaneous microinfusion pump to be clinically proven for the treatment of hyperemesis gravidarum during pregnancy and, therefore, medically necessary when ALL of the following criteria are met:

<table>
<thead>
<tr>
<th>Clinical criteria (ALL criteria must be met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperemesis gravidarum is diagnosed after nine weeks of gestation.</td>
</tr>
<tr>
<td>All other causes of nausea and vomiting have been ruled out.</td>
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<tr>
<td>Evidence of persistent vomiting, weight loss of more than 5 percent.</td>
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<tr>
<td>Documentation of one of the following: ketouria, hypokalemia or high urine specific gravity (dehydration).</td>
</tr>
</tbody>
</table>


II. Arbor Health Plan considers the use of intravenous (IV) hydration (CPT codes 96360, 96361) for hyperemesis gravidarum to be clinically proven and, therefore, medically necessary when either of the following criteria is met:

<table>
<thead>
<tr>
<th>Clinical criteria</th>
<th>(Either criterion must be met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of clinical signs of dehydration (e.g., high urine specific gravity, ketonuria or hypokalemia).</td>
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<tr>
<td>Inability to tolerate oral liquids without vomiting for more than three weeks.</td>
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</tbody>
</table>

- IV hydration should be continued until ketosis and vitamin deficiency have been corrected and until the patient can tolerate oral fluids.
- At any step consider parenteral nutrition if dehydration persists or persistent weight loss is noted.
- Alternative therapies may be added any time depending on patient acceptance and clinician familiarity.
- Thiamine, 100 mg daily, IV for 2 – 3 days (followed by IV multivitamins) is recommended for every woman who requires IV hydration and has vomiting for more than three weeks.

A step trial in the following order unless contraindicated:

1.) A trial of at least one of the following five drugs has been attempted and failed:
   1. Prochlorperazine (Compazine IM/PO).
   2. Trimethobenzamide (Tigan PR).
   3. Promethazine (Phenergan IM/PO/PR).
   4. Metoclopramide (Reglan PO).
   5. Ondansetron (Zofran PO).

2.) If control not achieved with drugs in step #1, then a trial of doxylamine and pyridoxine (Diclegis® PO) has been attempted.

3.) If drugs in steps #1 and #2 have been tried without success, then either intravenous metoclopramide (Reglan) or intravenous ondansetron (Zofran) has been attempted and failed.

4.) Upon failure of drugs in steps #1, #2 and #3, the continuous infusion of ondansetron (Zofran).
Limitations of coverage:
All other uses of Zofran subcutaneous microinfusion pumps are not medically necessary. All other uses of IV hydration for hyperemesis during pregnancy (e.g., prevention of dehydration) are not medically necessary.

- In general, an imbalance of less than 500 ml of volume is not likely to require IV rehydration. Therefore, rehydration with the administration of an amount of fluid equal to or less than 500 ml is not medically necessary.

Note: The following CPT codes are not included in the Nebraska Medicaid fee schedule:

99601 - Home infusion/specialty drug administration, per visit (up to 2 Hours) each additional hour (List separately in addition to code for primary procedure)

99602 - Each additional hour.

99362 - Each additional hour. (List separately in addition to code for primary procedure.)

S9351 - Home infusion therapy, continuous or intermittent antiemetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Alternative Covered Services:
- Nutritional counseling, physician office visits.

Background

Nausea and vomiting of pregnancy affects approximately 80 percent of pregnant women (Einarson 2013). Uncomplicated nausea and vomiting of pregnancy, commonly known as “morning sickness,” is generally a mild, self-limited condition that may be controlled with conservative measures. A small percentage of pregnant women have a more profound course, with the most severe form being hyperemesis gravidarum (HG). Severe hyperemesis requiring hospital admission occurs in 0.3 percent – 2 percent of pregnancies (Einarson 2013, Piwko 2013).

There is no one accepted definition of HG. According to the American College of Obstetricians and Gynecologists (ACOG), the most commonly cited criteria for HG include persistent vomiting not related to other causes, a measure of acute starvation (usually large ketonuria), and some discrete measure of weight loss, most often at least 5 percent of pre-pregnancy weight. Electrolyte, thyroid, and liver abnormalities may be present (ACOG 2014). The International Statistical Classification of Disease and Related Health Problems, Ninth Revision (ICD-9-CM) defines HG as persistent and excessive vomiting starting before the end of the 22nd week of gestation; HG is further subdivided into mild and severe, with severe being associated with metabolic disturbances, such as carbohydrate depletion, dehydration, or electrolyte imbalance (AMA 2014).
While the etiology of HG unknown, it is most likely a multifactorial condition and has been associated with largely non-modifiable risk factors. HG is associated with family history (genetics) or a history of HG in a previous pregnancy (ACOG 2004). Hyperemesis is also associated with female gestation, multiple gestation, triploidy, trisomy 21, current or prior molar pregnancy, and hydrops fetalis. Additionally, women with a history of motion sickness, migraine headaches, psychiatric illness, pregestational diabetes, being underweight pregestation, hyperthyroidism, pyridoxine deficiency, and gastrointestinal disorders are at an increased risk. Women with HG are more likely to be younger, pregnant for the first time, persons of color, and less likely to drink alcohol. Limited evidence suggests infection with *Helicobacter pylori* may play a role in the development of HG in some women (ACOG 2004, McCarthy 2014).

Other factors have been implicated in the etiology of HG, but their association with HG has not been established. These include body mass index, smoking, socioeconomic status estrogen, stress, depression, and free human chorionic gonadotropin (hCG) (McCarthy 2014).
Unlike morning sickness, HG may have negative implications for maternal and fetal health. Women with uncomplicated nausea and vomiting of pregnancy have been noted to have improved pregnancy outcomes, including fewer miscarriages, preterm deliveries and stillbirths, as well as fewer instances of fetal low birth weight, growth retardation and mortality (Vandraas 2013, Veenendaal 2011). In contrast, HG has been associated with increases in maternal adverse effects, including splenic avulsion, esophageal rupture, Mallory-Weiss tears, pneumothorax, peripheral neuropathy, and preeclampsia, as well as increases in fetal growth restriction and mortality.

Early evaluation of nausea and vomiting during pregnancy is essential for preventing delay in diagnosis, as it may prevent progression to HG. Diagnosing HG is determined primarily by ruling out other underlying complications associated with persistent vomiting, such as gastrointestinal conditions (e.g., hepatitis, pancreatitis or biliary tract disease), pyelonephritis, and metabolic disorders (e.g., diabetic ketoacidosis, porphyria, or Addison’s disease) (Niebyl 2010). Laboratory assessment may help in the differential diagnosis of HG and assessment of its severity, but studies of diagnostic biomarkers for HG have produced inconsistent results (Niemeijer 2014).

Once other causes of nausea and vomiting in pregnancy have been ruled out, the management of HG is based on correcting electrolyte imbalance and dehydration, prophylaxis against recognized complications, and providing symptomatic relief (McCarthy 2014). Treatment may be administered singularly or in combination in inpatient and outpatient settings.

Pharmacologic approaches for the treatment of nausea and vomiting in pregnancy have been based on the pathophysiology of nausea and vomiting, and on treatments found to be safe and effective for non-pregnant subjects. Guidelines encourage early, safe and effective treatment with vitamins and non-pharmacologic alternatives that may prevent complications or reduce the need for pharmacologics or IV hydration and hospitalization associated with HG (ACOG 2004, Arsenault 2002). Non-pharmacologic options such as ginger, acupressure, acupuncture and chiropractic may be offered for symptom relief.

Pharmacological treatments include antihistamines, anticholinergics, dopamine antagonists, 5-HT3 antagonists, corticosteroids, cisapride, and cannabinoids (Niebyl 2010). If oral and intravenous (IV) administrations prove inadequate, subcutaneous drug microinfusion may be necessary.

Infusion pumps are used for many clinical applications, including IV, epidural, and subcutaneous delivery of analgesic and anesthetic, antibiotics, cardiovascular drugs, antiemetic and insulin. Drug delivery via infusion reduces the plasma drug concentration fluctuation associated with oral delivery and the slow onset and long depot effect associated with transdermal patch delivery. Infusion pumps are commonly used with continuous, intermittent or pulsatile delivery of drug is needed. They also provide an alternative for patients intolerant to oral administration and can be programmed to achieve special delivery profiles.
- IV hydration should be continued until ketosis and vitamin deficiency have been corrected and until the patient can tolerate oral fluids.
- At any step consider parenteral nutrition if dehydration persists or persistent weight loss is noted.
- Alternative therapies may be added any time depending on patient acceptance and clinician familiarity.
- Thiamine, 100 mg daily, IV for two – three days (followed by IV multivitamins) is recommended for every woman who requires IV hydration and has vomiting for more than three weeks.

Recently, a compact, disposable drug delivery device that incorporates a relatively short, 5-mm-long hypodermic needle has been shown to continuously and subcutaneously infuse drug solutions. This type of device can be worn on the skin in a discrete and convenient manner and deliver drug from a pressure-driven reservoir through the needle into the skin. Micro needles can be coupled with a micropump to make a wearable infusion device that is highly patient friendly and can serve as a potential replacement for conventional hypodermic needles and infusion sets. Microneedles are expected to be safe because they are minimally invasive devices that are inserted only into skin’s superficial layers and are typically bloodless and painless.

In the mid-1980s, continuous subcutaneous antiemetic therapy was widely employed in clinical practice for treating nausea and vomiting in pregnancy, despite the dearth of published clinical evidence to support the intervention. At that time, physicians began prescribing continuous subcutaneous metoclopramide (Reglan) via a portable, programmable Micro-infusion pump (MiniMed 404SP-MiniMed Technologies, Sylmar, Ca.) called the Reglan pump. In the late 90s, after ondansetron (marketed in the U.S. as Zofran) was widely promoted as an anti-emetic for patients with chemotherapy-induced nausea and vomiting, obstetricians began prescribing it in much the same way as had been done a decade earlier with metoclopramide. This became commonly referred to as a Zofran pump.

Correction of dehydration with IV fluid is one of the key aims of management (Bottomley 2009). The volume of fluid should be adequate to replenish the deficit and continuing loss through vomiting, as well as to meet normal fluid and electrolyte requirements. Sodium chloride IV infusion 0.9% (“normal” or “physiological” saline) is generally preferable, and compound sodium lactate IV solution containing other electrolytes (chloride, lactate, potassium and calcium), as well as sodium chloride may be used. Fluid replacement can be tailored to ketonuria or electrolytes and stopped once these have normalized and normal diet has resumed (Bottomley 2009).

An online survey of women with a history of HG found that over the last two decades, use of IV hydration has nearly doubled, along with use antihistamines, bed rest and vitamins (Goodwin 2008). Yet, this same survey found significant continued under-prescribing of vitamins, such as pyridoxine and thiamine during
pregnancy when HG commonly presents. Respondents living in the U.S. appear to have been treated primarily with ondansetron, which is more expensive than conventional antiemetics (Goodwin 2008).

A survey of ACOG fellows who constitute the Collaborative Ambulatory Research Network (CARN) reported that those who were familiar with the ACOG (2004) guidelines were more aware of the need for early, aggressive treatment to prevent progression to HG and were more likely to recommend ginger (59.7 percent vs. 47.9 percent, $p = 0.014$) and prescribe vitamin B6 (84.1 percent vs. 73.8 percent, $p = 0.005$) and vitamin B6 plus doxylamine (70.9 percent vs. 59.3 percent, $p = 0.009$) (Power 2007). Both surveys suggest continued underuse of early safe and effective treatment with vitamins and non-pharmacologic alternatives that may prevent complications or reduce the need for IV hydration and hospitalization associated with HG.

**Searches**

Arbor Health Plan searched PubMed and the databases of:

- UK National Health Services Center for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on September 3, 2015. Searched terms were: "hyperemesis gravidarum (MeSH)", "nausea vomiting of pregnancy (MeSH)" and "morning sickness (MeSH)."

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

- **Guidelines based on systematic reviews**.

- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Limited high-quality research is available to inform clinical practice on advanced treatment of HG. The ACOG summarized the evidence for guidance on treatment of nausea and vomiting during pregnancy and serves as the basis of this policy (ACOG 2004). The ACOG guidance focuses on treatment for all stages of
nausea and vomiting of pregnancy, as failure to treat early manifestations of nausea and vomiting of pregnancy increases the likelihood of hospital admission for HG. ACOG presents an algorithm of treatment options according to the strength of evidence for fetal safety and efficacy of treatments available in the U.S. A Cochrane review determined there was insufficient strong evidence of safety and effectiveness to support any one intervention over another (Matthews 2014). In the absence of one pharmacologic regimen clearly demonstrating benefit over any other, a decision algorithm that begins with the most cost-effective and readily accessible treatment options as depicted in the ACOG treatment hierarchy is a reasonable approach to managing HG, although evidence suggests that greater adherence to these guidelines may be needed (Power 2007, Goodwin 2008).

- ACOG recommends treatments with the strongest safety-efficacy profile as first-line treatments. These include dietary changes, emotional support, vitamin B6 and doxylamine (ACOG 2004).
- Pharmacologic management is indicated for relatively mild cases and progressing to patients who cannot tolerate oral treatment or are dehydrated, or both. Sufficient data on the safety of antihistamines, phenothiazines and metoclopramide in early pregnancy show no teratogenicity with any of these agents. Therefore, antiemetic treatment should not be withheld on the basis of teratogenicity concerns.
- For use of continuous subcutaneous anti-emetic therapy for treatment of nausea and vomiting during pregnancy, the entire body of evidence consists of five industry-sponsored and authored nonrandomized reports. These therapies do not appear, based on published payment levels, to be cost-effective when compared to conventional treatment alternatives, including episodic hospitalization (Reichmann, 2012). Managed care organizations that design evidence-based clinical coverage guidelines may want to limit their use to extremely recalcitrant cases of HG until sufficiently powered, independent, randomized, controlled trials demonstrate clinical efficacy and cost-effectiveness.
- IV hydration should be used for the patient who cannot tolerate oral liquids for a prolonged period or if clinical signs of dehydration are present. Signs of dehydration may include:
  - Decreased skin turgor.
  - Postural changes in blood pressure and pulse.
  - Abnormal electrolyte, BUN, creatinine, and serum ketone levels.
  - Abnormal urine specific gravity and ketone levels.
  - IV hydration should be continued until ketosis and vitamin deficiency have been corrected and until the patient can tolerate oral fluids. IV thiamine 100 mg daily for two to three days (followed by IV multivitamins) is recommended for every woman who requires IV hydration and has vomited for more than three weeks.
  - The evidence is inconclusive for determining if there is any clinical benefit of using a compound solution over normal saline 0.9%. One study randomized women with HG to either treatment with IV 5% dextrose and saline vs. normal saline for rehydration (Tan 2014). All participants received IV thiamine and an antiemetic. Women treated with 5% dextrose experienced short-term (< 24 hours) improvement in vomiting, but the effects
had dissipated by 24 hours. Other outcomes were similar between groups. These results suggest no clear advantage of a compound solution over normal saline for rehydration. Administering dextrose may stop the breakdown of fat, but it may also precipitate Wernicke encephalopathy in the presence of a thiamine deficiency. For any patient in whom vitamin deficiency is a concern, thiamine 100 mg should be given before initiating dextrose-containing fluids.

- Other interventions such as enteral tube feeding may be needed to serve as either as a supplemental or primary source of nutrition.

- Hospitalization is recommended when a woman cannot tolerate liquids without vomiting and has not responded to outpatient management. No controlled trials have compared hospitalization with outpatient management of HG. The option of hospitalization for observation and further assessment should be preserved for patients who experience a change in vital signs or a change in affect or who continue to lose weight. After the patient has been hospitalized on one occasion and a workup for other causes of severe vomiting has been undertaken, IV hydration, nutritional support, and modification of antiemetic therapy often can be accomplished at home. Greater awareness of evidence-based guidance, particularly for safe and effective early prevention strategies using vitamins/B6 therapy, is needed as are high-quality studies that focus on safe non-pharmacologic treatments, preventive measures in high-risk women, new biomarkers underlying the etiology of HG, and interventions that may reduce adverse pregnancy outcomes (McCarthy 2014).

Policy updates:

- A recently completed randomized controlled trial comparing the effect of day care services versus standard inpatient management on duration of hospitalization and patient satisfaction for the initial treatment of nausea and vomiting of pregnancy, including HG, will soon publish its findings (Clinicaltrials.gov NLM identifier: NCT00795561).

- A systematic review and economic evaluation is underway in the United Kingdom to assess the relative clinical- and cost-effectiveness of interventions for HG has not yet been published.

Summary of Clinical Evidence

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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8
<table>
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<tr>
<th>Author</th>
<th>Year</th>
<th>Key Points:</th>
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</table>
| Reichmann 2012 |      | - Randomized, controlled trials of sufficient power are necessary before long-term continuous subcutaneous metoclopramide or ondansetron can be used on a widespread basis to treat nausea and vomiting during pregnancy.  
- Cost approximations in the case series are reported and, when compared to the cost of other methods of treatment previously published in the medical literature, the therapy appears to be cost-prohibitive. However, definitive statements cannot be made regarding cost-effectiveness until clinical efficacy is demonstrated through a sufficiently powered, well-designed, randomized control trial (RCT).  
- Until such time, the therapy should remain experimental and coverage is restricted to intractable Hyperemesis gravidarum (HG) that is unresponsive to more-conventional treatment options. |
| Naef (1995)     |      | - Retrospective, matched control study 50 women with hyperemesis were treated in the home and were matched for gravidity, gestational age, and weight loss from prepregnancy weight with 47 patients who were hospitalized for traditional treatment.  
- The mean percent of weight loss at initiation of therapy was similar in both groups (4.6% +/- 5.7% vs 4.5% +/- 6.1%, not significant).  
- The mean weight change during therapy in the home group was +1.0 +/- 4.3 pounds compared with +1.2 +/- 8.6 pounds in the hospitalized group (not significant).  
- At discontinuation of therapy 90% of the home patients no longer required any supportive therapy; 10% (n =5) required hospitalization because of relapse.  
- The cost of therapy was significantly lower for patients in the home group ($708 +/- $533 vs $2701 +/- $1717, p < 0.001). |
| Buttino (2000)  |      | - Between January and December of 1997, 646 women with HG received continuous subcutaneous metoclopramide on an outpatient basis.  
- A total of 413 patients (63.9%) had complete resolution of symptoms.  
- Seventy-five percent of patients had received one or more antiemetic medications before initiation of s.c. metoclopramide.  
- A total of 192 patients (30.5%) reported at least one side effect related to treatment.  
- The majority of reported side effects was considered mild and did not require discontinuation of s.c. metoclopramide. |
- There is a lack of high-quality evidence to support any particular intervention.  
- The difficulties in interpreting and pooling the results of the studies of HG highlight the need for specific, consistent and clearly justified outcomes and approaches to measurement in research studies. |

Glossary

**Antiemetic** — A drug that is effective against nausea and vomiting.

**Dehydration** — A condition that occurs when the loss of body fluids, mostly water, exceeds the amount taken in.
Emetogenic — Having the capacity to induce emesis (vomiting), a common property of anticancer agents, narcotics and morphine.

Hyperemesis gravidarum (HG) — Severe nausea and vomiting during pregnancy that can lead to loss of weight and body fluids.

Infusion pump — A medical device that delivers fluids, such as nutrient, and medications, into a person’s a body in controlled amounts. Infusion pumps are in widespread use in clinical settings such as hospitals, and in the home.

Ketonuria — A condition in which abnormally high amounts of ketones and ketone bodies are present in the urine.

Ketosis — A metabolic state that produces ketones, which are byproducts of burning fat for fuel when the diet does not provide sufficient carbohydrate to replenish glycogen stores. Excessive ketone levels can dull the appetite and cause nausea. Ketones that are not used for fuel are excreted the kidneys and the urine.

Microinfusion pump — Microinfusion pumps (MIPs) are used to administer medications at low infusion rates and for chemotherapy and analgesia.

NVP — Nausea and vomiting of pregnancy.

Ondansetron (Zofran) — A selective 5-hydroxytryptamine (3) (5-HT (3)) receptor antagonist that has been introduced to clinical practice as an antiemetic for cancer treatment-induced and anesthesia-related nausea and vomiting. Its use under these circumstances is both prophylactic and therapeutic.

Parenteral nutrition - Intravenous feeding.

S.C. - Subcutaneous.

Wernicke encephalopathy - A serious neurologic disorder caused by Thiamine (vitamin B-1) deficiency.

References

Professional society guidelines/others:


Peer-reviewed references:


**Clinical Trials:**


Centers for Medicare & Medicaid Services (CMS) National Coverage Determination

The NCD for infusion pumps at section 280.14 sets forth specific coverage criteria under sections A- D. Under section B.1.f other uses of external infusion pumps are covered if the contractor’s medical staff verifies the appropriateness of the therapy and the prescribed pump for the individual beneficiary.

Local Coverage Determinations

Commonly Submitted Codes
Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours) each additional hour.</td>
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<tr>
<td>99602</td>
<td>Each additional hour.</td>
<td>List separately in addition to code for primary procedure</td>
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<tr>
<td>96360</td>
<td>Intravenous infusion, hydration; initial, 31 minutes to 1 hour. (Do not report 96360 if performed as a concurrent infusion service.) (Do not report intravenous infusion for hydration of 30 minutes or less.)</td>
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<tr>
<td>96361</td>
<td>Each additional hour. (List separately in addition to code for primary procedure.) (Use 96361 in conjunction with 96360.) Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service (96360, 96365, 96374, 96409, 96413) is administered they the same IV access</td>
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<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>643.00</td>
<td>Mild hyperemesis gravidarum; starting after nine (9) weeks of gestation.</td>
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<tr>
<td>643.03</td>
<td>Mild hyperemesis gravidarum, antepartum condition or complication.</td>
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<tr>
<td>ICD-10 Code</td>
<td>Description</td>
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<tr>
<td>O21.0</td>
<td>Mild hyperemesis gravidarum</td>
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<tr>
<td>O21.1</td>
<td>Hyperemesis gravidarum with metabolic disturbance</td>
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<tr>
<td>O21.2</td>
<td>Late vomiting of pregnancy</td>
<td></td>
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<tr>
<td>O21.8</td>
<td>Other vomiting complicating pregnancy</td>
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<tr>
<td>O21.9</td>
<td>Vomiting of pregnancy, unspecified</td>
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<tr>
<th>HCPCS Level II</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>J2405</td>
<td>Injection, Injection,(Zofran) ondansetron hydrochloride, per 1 mg.</td>
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<tr>
<td>J2765</td>
<td>Injection, Reglan (metoclopramide HCl), up to 10 mg.</td>
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<tr>
<td>E0779</td>
<td>Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater.</td>
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<tr>
<td>E0780</td>
<td>Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours.</td>
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<tr>
<td>E0781</td>
<td>Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient.</td>
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<tr>
<td>S9351</td>
<td>Home infusion therapy, continuous or intermittent antiemetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem.</td>
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