Many readers have asked if intravenous immune globulin (IVIG) is covered in the homecare setting under Medicare Part B or Part D.

**Answer:** This question is extremely important, and the answer depends on your diagnosis. If you have a primary immune deficiency disease (PIDD), you are covered under Medicare Part B, and your coverage includes reimbursement for the drug only; it does not cover nursing services to administer the IVIG or durable medical equipment, such as a pump.

The reimbursement for IVIG in the homecare setting under Medicare Part B is at the same rate as in the physician’s office (although physicians can also bill separately for administration of the IVIG), so it will be difficult to find a homecare company that will provide IVIG for PIDD patients as long as the reimbursement rate continues to be lower than the cost.

If you are told that you are or would be covered under Medicare Part D for IVIG therapy for PIDD, this is not the case and you should not sign up for Medicare Part D for such coverage. However, Part D will cover your other prescriptions, so if you do not have a secondary insurance, you should consider Part D for your other prescriptions.

If you have a diagnosis other than PIDD, such as chronic inflammatory demyelinating polyneuropathy (CIDP), Guillain-Barré syndrome, idiopathic thrombocytopenic purpura (ITP), myositis, myasthenia gravis or other disorders normally covered by Medicare in the physician’s office or hospital outpatient setting, Medicare Part D should cover your IVIG in the homecare setting.

Although, like Part B, Part D does not cover nursing services or durable medical equipment, the reimbursement rate for IVIG is higher in Part D than in Part B, which increases the likelihood that homecare companies will be able to serve you.

Please remember that you will have to pay out-of-pocket expenses until you reach $3,850 (including the deductible, copay and the “doughnut hole”), and then you should be covered at 95 percent to 100 percent for the rest of the year, depending upon your policy.

Please review all of the Medicare Part D policies: Some of the policies may offer supplemental coverage during the “doughnut hole” period or may assist with the $3,850, if this is a financial burden.

A newly diagnosed CIDP Medicare patient asked how she can afford to receive her IVIG. Her physician does not provide IVIG in his office, her local hospital is not taking new patients, and the homecare company to which she was referred said her treatment would cost $11,000 per month.

**Answer:** If you have Medicare and have a diagnosis other than PIDD, you should consider signing up for a Medicare Part D policy. The patient in this case does have
Medicare Part D, but the homecare company did not understand how the coverage is implemented: The patient must pay out-of-pocket expenses up to $3,850, including the deductible, copay and doughnut hole, at which point Medicare Part D will cover 95 percent to 100 percent, depending on the policy. Additionally, if you have a secondary insurance other than Medicare, your nursing services for administering the IVIG will also be covered.

This patient was able to afford to pay $3,850 out of pocket, and the homecare company had the IVIG brand that she needed, so, after a little education, the problem was solved, and the patient is currently receiving her IVIG in her home.

A patient with PIDD asked how to resolve her insurance dilemma. She was applying for disability and her case was scheduled to be seen by an administrative judge. She decided to stop the process of trying to obtain disability because of the reimbursement problems for IVIG under Medicare and because she has another healthcare policy. She thought that she would be forced to have Medicare become her primary insurance coverage in the physician's office. She also thought that, if she turned down Medicare, she would not be able to receive her Social Security check when she turns 65.

**Answer:** When you apply for Medicare either under disability or when you turn 65, Medicare Part A is mandatory. Medicare Part A covers your hospital inpatient services. Currently, the IVIG reimbursement crisis has not affected Medicare Part A, because it is not necessary for most IVIG patients to receive their infusions in the inpatient setting.

Medicare Part B is where the majority of the reimbursement problems for the IVIG community are occurring. Medicare Part B is optional when you apply for Medicare. If you are covered by a health insurance plan other than Medicare, and want to keep your current insurance policy as your primary, discuss that option with your health insurance benefits manager and Medicare, and determine if you should obtain Medicare Part B benefits.

Medicare Part D is an optional prescription drug plan that should be considered by all patients, regardless of diagnosis, for their prescription drugs—just remember that Part D will not cover IVIG for patients with PIDD, so, again, such patients need Part B to cover their IVIG.

**Linda of Rhode Island asked** how she can get Medicare to pay for her treatment when the guidelines are neither clear nor realistic. She said she is required to have her blood tested every three months, and, based on the test results, Medicare is reducing the number of grams of IVIG she receives, even though she is having severe infections.

**Answer:** In Linda’s case, the local Medicare carriers for Rhode Island, Blue Cross and Blue Shield and Mutual of Omaha, have implemented a **local coverage determination** (this is a very important term for patients to learn) for PIDD patients who require serum trough level testing every three months. The serum trough levels must be no higher than 400 to 600 mg/dl in order for patients to continue to receive their infusions at their current dosage and frequency. If the levels are higher, the hospital can reduce the number of grams per infusion or increase the number of days between infusions until the trough level drops to 600 mg/dl or lower. For many PIDD patients, this level is too low and results in increased and/or more severe infections. Additionally, the local coverage determinations for dosing are inadequate. The initial IVIG dose is 200 to 400 mg/kg body weight and maintenance doses are 100 to 200 mg/kg body weight, administered approximately once per month. According to the American Academy of Allergy, Asthma and Immunology, the usual IVIG dose for antibody replacement is 300 to 600 mg/kg per month, delivered every two to four weeks through intravenous route; and an acceptable starting point for maintenance dosing is 400 mg/kg every three to four weeks. In fact, because Linda tested outside of Medicare’s target range and the new dosing requirement, they reduced her monthly IVIG dosage, which has resulted in her having continuous, severe infections.

Rhode Island is one of 47 states that have implemented local coverage determinations for PIDDs that can include at least this restriction, and some states are imposing additional restrictions that can also lead to inadequate IVIG treatment. Such local coverage determinations do not appear to be based on sound medical science, and they are affecting PIDD patients and patients who rely on IVIG for other indications.

**Editor’s note:** Please check our next issue of IG Living (April-May 2007) for a follow-up story on Medicare local coverage determinations. We will include all of the current restrictions in place, by diagnosis and state.

Please contact IG Living if your treatment has been detrimentally impacted by a local coverage determination, so we can continue to compile information about the effects of such determinations on patients' quality of care.

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