**Medicare and IG**

Does Medicare pay for immune globulin (IG) therapy? This question ranks among the most frequently asked of *IG Living* by both patients and doctors. The easy answer is yes. Medicare does pay for IG when medically necessary for all FDA-approved indications, as well as a number of off-label indications. Unfortunately, how Medicare pays and under what circumstances is not nearly that simple.

**Alphabet Soup**

Medicare is commonly referred to as alphabet soup because the different plans are named as letters (i.e., Part A, Part B, Part C, etc.). Which letter covers IG and how much it covers depends primarily on the subscriber’s plan choice, where the treatment takes place and what disease the patient has. For a list of disease states covered by Medicare, see the website address at the end of this article.

**Part B Plus Medigap**

Both intravenous IG (IVIG) and subcutaneous IG (SCIG) therapy are covered under Medicare Part B. This plan covers medically necessary services such as doctor appointments, durable medical equipment, preventive services and outpatient treatments. Payment and coverage decisions for IG under Medicare Part B is administered by one of the four regional Durable Medical Equipment Medicare Administrative Contractors (DME MACs), which are named regions I, II, III and IV. Part B covers 80 percent of the contracted rate for IVIG and SCIG.

In order to get more than 80 percent coverage, patients must have additional coverage such as a Medigap plan (also known as a supplemental plan). Medigap plans are administered by private insurers. In general, they cover the 20 percent gap that Medicare Part B does not cover. Unfortunately, for the disabled under age 65, federal law does not currently require insurance companies to sell Medigap plans to them. That requirement is left up to the states. As of this writing, 27 states mandate that a Medigap plan be made available to the disabled under age 65. To see a complete list of participating states, go to [www.medicare.gov/Publications/Pubs/pdf/02110.pdf](http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf).

In lieu of a Part B plus Medigap plan, Medicare recipients may choose a Medicare Advantage plan (also known as Medicare Part C) or, if available, they can be privately insured through a working spouse or retirement plan.

**Part C/Advantage Plans**

Medicare Advantage plans are administered by private insurance companies. They are an inclusive plan that must cover traditional Medicare benefits (Parts A and B), with the exception of hospice, which falls back to traditional Medicare. Medicare recipients choosing an Advantage plan cannot have a Medigap plan. Medicare Advantage/Part C plans must cover at least the same as traditional Medicare. This means that Advantage plans must cover at least 80 percent of the contracted rate of IG under the medical part of the policy. Often, however, several plans cover more than 80 percent. Additionally, like traditional insurance, these plans typically have a maximum out-of-pocket after which coverage is 100 percent.

Keep in mind that even though Advantage plans must cover at least what traditional Medicare covers, no two plans are the same. Those considering Advantage plans need to clarify all the details before agreeing to
purchase the plan. Last, many Advantage plans include drug coverage. Therefore, subscribers may not need to purchase an additional drug coverage plan.

Medicare Advantage plans may be an attractive alternative for those under age 65 who qualify for Medicare coverage due to a disability if they live in one of the states that do not offer Medigap plans.

Plan D/Prescription Coverage

Medicare Part D is for prescription drug coverage. Having a Part D plan in addition to Medicare Part B is known as a stand-alone drug plan. In general, patients with a disease other than primary immunodeficiency disease (PIDD) may receive IVIG under the Part D benefit. However, only the drug is covered; nursing and supplies are not generally covered under stand-alone Part D plans. Additionally, if receiving IVIG under Part D, there is a coverage gap, not so affectionately known as the doughnut hole, in which the patient is financially responsible for 100 percent of the charges until they reach their out-of-pocket maximum.

Drug Coverage Under Advantage Plans

While an Advantage plan also may include a drug benefit, it is not considered a stand-alone plan. As a result, the plan may differ from traditional Medicare Part D plans. Consequently, PIDD patients using SCIG may be able to access their medication using the prescription benefit of an Advantage plan. Patients doing this, however, could be subject to higher out-of-pocket costs than traditional Medicare plus Medigap. Advantage plan members should clarify with their IG provider as to which benefit they are accessing to pay for services before agreeing to receive the medication.

Where Treatments Take Place Matters

Whether IG is covered under Part B, Part C or Part D, where the treatment occurs makes a difference. Additionally, the amount that is reimbursed can and does vary depending on the setting. All infusion providers and specialty pharmacies are required to use a specific code that tells Medicare where the IG is infused. If the place of service code does not match Medicare policies, the entire claim could be denied.

Home. Currently, Medicare will cover immune globulin in the home under certain circumstances:

1. If the patient is certified home-bound and the diagnosis is one covered under Medicare, nursing and the medication are covered under Medicare Part B.
2. If the patient has a PIDD and uses IVIG, only the drug is covered in the home setting. Nursing and supplies are the responsibility of the patient.
3. If the patient uses an IG product that is FDA-approved to be infused subcutaneously, the medication and supplies are covered. However, nurse training in the home setting is not covered.
4. If the patient has a disease that is not PIDD, such as chronic inflammatory demyelinating polyneuropathy (CIDP) or polymyositis, for example, coverage for the drug is available only under Part D. Again, nursing and supplies are the financial responsibility of the patient. Because of the aforementioned doughnut hole, this may not be an attractive option for patients.

Doctor’s office/infusion clinic. Many patients find comfort in knowing that a doctor or a well-trained nurse is close by during their infusion. Medicare will cover IG infusions in a clinical setting as long as the provider is a contracted Medicare provider. The types of clinics that may provide IG therapy include cancer centers, rheumatology clinics and neurology clinics. Reimbursement for IG in this setting should fall under Part B for traditional Medicare or the medical portion of an Advantage plan policy.

Outpatient hospital. Medicare will cover infusions under Part B in an outpatient hospital setting as long as the hospital is a contracted Medicare provider. For Advantage plans, care should fall under the medical portion of the plan. All services and supplies needed for the infusion should be included in the coverage.

Confusion Prevails

Even though Medicare does cover IG therapy, the confusion over how it is covered still worries patients and providers. And, because medicine is in a constant state of evolution, the rules will always be subject to change. Patients and providers, therefore, are wise to gather as much information as possible to help them make the most informed decisions.

Source: http://www.medicare.gov
Medicare Coverage Database: www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=50875&ver=9&ContrId=238&ContrVer=2&ContrtrSelected=238*2&Cov erageSelection=Both&ArticleType=All&PolicyType=Final&=All&KeyWord=IVIG&KeyWordLook Up=Title&KeyWordSearchType=And&clickon=search&bc=gAAAAABAAAAA&