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Intravenous Immune Globulin Items & Services

What's Changed?

- Refined claims processing instructions for the intravenous immune globulin (IVIG) permanent benefit (pages 1–4)
- Added IVIG coverage information (page 1)
- Added CY 2025 payment rate for Q2052 (page 2)
- Added a time increment table for reporting Q2052 (page 3)
- Added a new IVIG J-code for CY 2025 (page 4)
- Added place of service code 04 for claims processing (page 4)

Substantive content changes are in dark red.

This fact sheet tells Medicare providers and suppliers about the intravenous immune globulin (IVIG) permanent benefit and gives information on:

- How the Consolidated Appropriations Act (CAA), 2023 governs payment for IVIG items and services
- How to bill IVIG items and services

The IVIG demonstration, authorized by the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 under Medicare Part B of Title XVIII of the Social Security Act, started in October 2014 and ended December 31, 2023. During the demonstration, we made a bundled payment under Part B for all items and services necessary to provide IVIG in the home for treating Primary Immune Deficiency Disease (PIDD) for eligible patients.

Starting January 1, 2024, we make a separate bundled payment for home IVIG items and services to DME suppliers. Section 4134 of the CAA, 2023 makes the IVIG in-home coverage permanent with no action needed for patients or eligible suppliers.

IVIG Coverage

Providers use Immune globulin (Ig) therapy to treat people with PIDD. Patients receive the IG drug through an IV or under the skin. We cover IVIG in the home under Part B if you meet all the following criteria:

- The IVIG is an approved pooled plasma derivative for the treatment of PIDD
- You're treating a patient diagnosed with PIDD
- You provide the IVIG in the home
- The patient's treating practitioner has determined that providing IVIG in the home is medically appropriate

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Supplier Eligibility

DMEPOS suppliers billing for IVIG services and supplies must meet the following conditions under section 4134 of the CAA, 2023:

- Meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG
- Be enrolled and current with the National Supplier Clearinghouse
- Be able to bill DME Medicare Administrative Contractors (MACs)

If a state requires licensure to provide certain items or services, a DMEPOS supplier:

- Must be licensed to provide the item or service
- May contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law

A DMEPOS supplier can't contract with any entity that's currently excluded from:

- The Medicare Program
- Any state health care program
- Any other federal procurement or non-procurement programs

Billing & Coding Requirements

We make a bundled payment for home IVIG items and services to DME suppliers. This payment is separate from the payment for the IVIG drug provided on the date of service. You'll decide if the services and supplies are appropriate and necessary to administer the IVIG in the home for each patient. This may or may not include using a pump; however, we don't cover a pump under the home IVIG items and services payment.

IVIG Visit Code

We established a "Q" code for services, supplies, and accessories used in the home for IVIG:

- Q2052 – (Long Description): Services, supplies and accessories used in the home for the administration of intravenous immune globulin (ivig)
- Q2052 – (Short Description): Home ivig, services/supplies

For CY 2024, the payment rate for Q2052 is $420.48. For CY 2025, the payment rate for Q2052 is $431.83.

Starting January 1, 2024, you don't have to bill Q2052 on the same claim as the drug code, but they must have the same place of service.

If you're billing for multiple administrations of IVIG on a single claim, then you should bill the Q-code for each infusion date of service on a separate claim line, which is payable per visit (in other words, each time you administer the IVIG).

Only 1 unit of Q2052 is payable per infusion date of service; however, you should report the infusion visit length in 15-minute increments (15 minutes = 1 unit). See the table below for the rounding of units.

Units	Time
1	<23 minutes
2	= 23 minutes to <38 minutes
3	= 38 minutes to <53 minutes
4	= 53 minutes to <68 minutes
5	= 68 minutes to <83 minutes
6	= 83 minutes to <98 minutes
7	= 98 minutes to <113 minutes
8	= 113 minutes to <128 minutes
9	= 128 minutes to <143 minutes
10	= 143 minutes to <158 minutes

Note: In cases where the drug is mailed or delivered to the patient before administration, the date of service for the administration of the drug (the Q2052 claim line) can't be more than 30 calendar days after the date of service on the drug claim line.

See Medicare Claims Processing Manual, Chapter 20, section 213 for more information on IVIG billing and coding requirements.

IVIG Drug Codes

The following "J" codes represent Ig drugs you give intravenously and are payable under Part B for services you provide in the home (or home-like setting) for patients with PIDD:

- Privigen (J1459)
- Asceniv (J1554)
- Bivigam (J1556)
- Gammaplex (J1557)
- Gamunex (J1561)
- Immune Globulin Not Otherwise Specified (J1566 and J1599)
- Octagam (J1568)
- Gammagard liquid (J1569)
- Flebogamma (J1572)
- Panzyga (J1576)

Starting January 1, 2025, you may also bill Alyglo (J1552).

Note: Ig drugs covered under Part B for IVIG administration in the home for patients with PIDD are subject to change.

IVIG Diagnosis Codes

Table 3 of CR 13217 shows the ICD-10 codes that support medical necessity for home administration of IVIG.

Claims Edits

You don't have to bill Q2052 on the same claim as the allowable drug J code. We'll:

- Reject the IVIG visit (Q2052) for claims if 1 of the allowable drug J codes isn't on the same claim or in Medicare's claims history within 30 days before the Q2052 date of service
- Deny the IVIG visit (Q2052) for claims when 1 of the allowable J codes isn't on the same claim or in our claims history within 30 days before the Q2052 date of service

If we reject the claim for no drug code in history, your MAC will recycle the IVIG Q2052 claim up to 3 times for a total of 15 business days until we find 1 of the drug J codes in history. If we don't find the drug claim in history after these 3 recycles, we'll deny the claim.

The claim must have a place of service code of 04, 12, 13, 14, 32, 33, 54, 55, or 56 or we'll reject the claim.

Resources

- 42 CFR 414 Subpart R – Home IVIG Items and Services Payment
- CY 2024 Home Health Prospective Payment System Final Rule (CMS-1780-F)