

**Medicare Patient IVIG Access Act of 2009**  
**Section-By-Section Summary**

**Section 1. – SHORT TITLE; TABLE OF CONTENTS**

Medicare Patient IVIG Access Act

**Section 2. – FINDINGS**

In April 2007 the OIG and ASPE submitted reports to Congress related to IVIG which found:

- During the third quarter of 2006, 44% of IVIG sales to hospitals and 41% to physicians occurred at prices above Medicare payment amounts.
- 61% of responding physicians had sent patients to hospitals for IVIG treatment, largely because of their inability to purchase IVIG at prices below the Medicare payment amounts.
- Home infusion providers generally do not accept new patients who have primary immune deficiency disease and only have Medicare coverage because providers are unable to acquire IVIG at Medicare reimbursed rates and because the Medicare Part B infusion benefit specific to these patients does not reimburse for the infusion services provided by a nurse.
- Physicians administering IVIG to Medicare beneficiaries are reimbursed at the same low complexity level as the administration of antibiotics. However the administration of IVIG requires special preparation and handling, involves significant patient risk, and prolonged nursing time to monitor the patient during infusion.

**Section 3. – MEDICARE PAYMENT FOR INTRAVENOUS IMMUNE GLOBULINS (IVIG).**

Requires the Secretary of Health and Human Services (HHS) to review existing data, including survey and pricing data, and collect any additional data on the differences, if any, between payments to physicians and hospital outpatient departments for IVIG within 6 months of enactment of the bill.

The Secretary shall determine within 7 months whether an add-on payment is appropriate. Authority for such an add-on payment is provided for 2 years from the time the Secretary determines whether an add-on payment is appropriate. The Secretary may continue to provide an add-on payment if MedPAC determines it improved beneficiary access to IVIG.

**Section 4. – COVERAGE AND PAYMENT OF IVIG IN THE HOME**

Provides Medicare coverage of items and services through the current law Part B home infusion benefit for Medicare patients with a primary immunodeficiency diagnosis.

**Section 5. – REVIEW OF INFUSION COMPLEXITY CODES FOR IVIG ADMINISTRATION**

Requires the Secretary of HHS to collect data or to review any existing data from providers, related to the practice of IVIG infusion and to evaluate which of the current infusion complexity codes is most appropriate for IVIG. Such data shall be collected and/or submitted to the Secretary within 6 months of enactment of the Medicare Patient IVIG Access Act and then CMS shall inform Medicare contractors under which code IVIG infusion shall be reimbursed.

**Section 6. – REPORTS**

Requires the Secretary of HHS to report back to Congress regarding whether she plans to use the authority for an add-on payment specific to IVIG and if not, why the payment is appropriate based on the data collected and reviewed.

Requires MedPAC to review whether the add-on payment authority was used and analyze beneficiary access to IVIG. Also, MedPAC is required to consider new payment methodologies for IVIG and whether the lag time in calculating the ASP can be reduced. Finally, MedPAC is required to submit any recommendations for legislative or administrative action related to IVIG payment.

**Section 7. – OFFSET**

Authorizes Medicare reimbursement of disposable elastomeric infusion pumps used for the treatment of colorectal cancer when prescribed by a physician in place of a durable pump.