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FACT SHEET
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Intravenous Immune Globulin Items & Services

What's Changed?

We added the CY 2026 payment rate for HCPCS code Q2052 (page 3).

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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This fact sheet tells Medicare providers and suppliers about the intravenous immune globulin (IVIG) permanent benefit and gives information about:

- How the Consolidated Appropriations Act, 2023 controls payment for IVIG items and services
- How to bill IVIG items and services

The IVIG demonstration, approved 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 stopped December 31, 2023. During the project, we made a combined payment under Part B for all items and services needed to provide IVIG at home for treating primary immune deficiency disease (PIDD) for eligible patients.

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

IVIG Coverage

Providers use immune globulin (Ig) therapy to treat people with PIDD. Patients get the Ig drug intravenously or under the skin. We cover IVIG in the home under Part B if you meet all these requirements:

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

We define a patient's home as a place of residence they use as a home, including an institution. A hospital, critical access hospital, or skilled nursing facility isn't an eligible institutional home setting.

Supplier Eligibility

DMEPOS suppliers billing for IVIG services and supplies must meet these requirements under section 4134 of the Consolidated Appropriations Act, 2023:

- Meet all Medicare regulations as well as other national, state, and local standards and regulations that apply to providing services related to IVIG home infusion
- Be enrolled 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
- Can contract with a licensed individual or other entity to provide the licensed services unless state law clearly forbids it

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 combined 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 each patient's home. This may or may not include using a pump, but we don't cover a pump under the home IVIG items and services payment.

IVIG Visit Code

We created a "Q" HCPCS 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 2025, the payment rate for Q2052 was $431.83. For CY 2026, the payment rate is $442.19.

You don't have to bill Q2052 on the same claim as the drug code, but they must have the same place of service (POS) code.

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 paid per visit.

Only 1 unit of Q2052 is paid per infusion date of service, but you should report the infusion visit length in 15-minute increments (15 minutes = 1 unit). See the table 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: When the drug is mailed or delivered to the patient before administration, you must administer the drug (the Q2052 claim line) within 30 days of the date of service on the drug claim line.

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

IVIG Drug Codes

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

- Privigen (J1459)
- Alyglo (J1552)
- 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)

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 Change Request 13217 shows the ICD-10-CM diagnosis 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:

- 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 the claim 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 the claim history. If we don't find the drug claim in the claim history after these 3 recycles, we'll deny the claim.

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

Resources

- 42 CFR 414 Subpart R for Home IVIG Items and Services Payment
- CY 2024 Home Health Prospective Payment System Final Rule
- Medicare Provider Compliance Tips – Intravenous Immune Globulin