Part D Benefit May Facilitate Formulary Appeals

Medicare's new provision offers quicker alternatives to getting exceptions for nonpreferred medications.

BY JENNIFER SILVERMAN
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WASHINGTON — Patients may find it easier to appeal denials of payment for medications under Medicare's new Part D prescription drug benefit than they do under other health programs, an analyst said during a meeting of the Medicare Payment Advisory Commission.

Specifically, the new benefit offers quicker alternatives to getting formulary exceptions for nonpreferred drugs than private plans or Medicaid, Joan Sokolovsky, Ph.D., a MedPAC senior analyst indicated. The new prescription drug benefit, a part of the Medicare Modernization Act of 2003, goes into effect in January.

MedPAC analysts reviewed the appeals processes in several private plans and in Medicaid to see how they compare with the upcoming Part D prescription drug benefit. The commission queried a number of stakeholders in these markets, including physicians, pharmacists, consumer advocates, health plan representatives, and pharmacy benefit manager representatives.

While Medicare's regulations on appeals generally support the processes of Medicaid and private health plans, MedPAC did find some fundamental differences, Dr. Sokolovsky said.

More situations are considered "coverage determinations" under the Part D benefit and may be appealed, she said. For example, Medicare beneficiaries will be able to appeal an increased copayment if they are prescribed a nonpreferred drug as opposed to a preferred drug. Dr. Sokolovsky said private plans reported having little experience with this kind of adjustment.

One physician who MedPAC analysts surveyed reported that his practice spends several hours per day trying to resolve prior authorization matters.

The time frame for handling exception requests is also shorter under Part D, Dr. Sokolovsky continued. "If under an urgent request for an exception, a [Medicare Part D] plan must handle these determinations within 24 hours. That's typically faster than required for most [private insurers] now."

Shorter, expedited time frames and the ability to appeal copays, however, may lead to an increased volume of appeals, and possibly higher premiums, she said.

To minimize appeals, Medicare Part D plans may put fewer restrictions on separate, tiered cost sharing on nonpreferred drugs. "Good communication is important to prevent an excessive increase in appeals," she said.

In some cases, physicians under Part D must get prior approval or authorization before nonpreferred drugs are covered.

From interviews with stakeholders, MedPAC learned prior authorization often creates burdens for beneficiaries and providers in commercial and Medicaid plans.

Prior authorization should ideally take place before the prescription is written—but often doesn't, Dr. Sokolovsky said.

"Physicians frequently don't know what the drugs are on their patients' formularies, or which ones require prior authorization." Patients often become aware of the need for prior authorization when the pharmacist tries to process the prescription and gets a notice that the drug is not covered, but lists other drugs that would be covered.

Private health plans tend to keep detailed information on the disposition of exception requests; however, some information never comes back to a plan, she said.

For example, the private plans MedPAC surveyed didn't seem to know how often a beneficiary paid for a drug when it was not covered, how often pharmacists contact physicians or the plan member when a drug isn't covered, or if the physician even had time to respond to the situation.

One physician reported his practice spends several hours a day trying to resolve prior authorization matters. Private plans have tried to ease this burden by educating members and physicians."Some plans deal with the burden by simply placing fewer drugs on prior authorization," she said. ■

PPAC Members Concerned About Part B Drug Proposal

BY JOYCE FRIEDEN
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WASHINGTON — Members of a Medicare physician advisory group have reservations about the Centers for Medicare and Medicaid Services' proposed new program for paying for physician-administered outpatient drugs under Medicare Part B.

Medicare currently pays physicians the average sales price (ASP) of the drug—a number that is supposed to represent the total paid for the drug by all buyers divided by the number of units sold—plus an additional 6%. But under the proposed rule, beginning next year physicians would have a choice: They could either stick with the current system or obtain the drugs directly from a vendor that will be selected by Medicare via a competitive bidding process.

The system would require that physicians choose one system or the other for all the drugs commonly furnished to their specialty; they could not get reimbursed ASP plus 6% for one drug and then buy another drug directly from the vendor, according to Don Thompson, director of outpatient services at CMS's Center for Medicare Management.

But Ronald Castellanos, M.D., a Cape Coral, Fla., urologist and chairman of the Practicing Physicians Advisory Council, said at a council meeting that an all-or-nothing system wouldn't work very well in his practice. "There are certain drugs that I use that I can't buy for ASP plus 6%."

Mr. Thompson said that while Dr. Castellanos couldn't pick and choose what system he would use for which drug, he could try to influence which urology drugs will be included in the program. "The categories could be structured differently; your comment [on the proposed rule] could be, 'I think the category should include these drugs and not these other drugs,'" Mr. Thompson said at the meeting. "But once a drug is in a category, the physician cannot opt in and out for that drug."

Dr. Castellanos proposed that the council, which advises Medicare on matters of interest to physicians, urge CMS to revise the rule to allow physicians to pick and choose which system they would use "on a drug-by-drug basis." That recommendation passed easily.

Both Dr. Castellanos and council member Barbara McAneny, M.D., an Albuquerque oncologist, expressed concern about what would happen to beneficiaries—usually, those without Medicare supplemental coverage—who couldn't afford the drug copays. "I want manufacturers to show up with free drugs for patients who have no bucks," Dr. McAneny said. "Physicians, because we're not good businessmen, have eaten that money, but now it's hard to do that because we're not making enough on ASP plus 6%."

Dr. Castellanos wondered whether the drug vendors who are going to contract with Medicare would be required to provide drugs for beneficiaries even if they didn't have the needed copays.

"The contractor would be required to supply that drug to you," Mr. Thompson replied. "There's no separate requirement for vendors that would be any different from physicians," who can waive the copay on a case-by-case basis, he said. ■

Medicare Pilot Project Starts To Look for Mistakes in Claims

BY JOYCE FRIEDEN
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WASHINGTON — Medicare providers in California, Florida, and New York, beware: Someone may be watching you.

This month, the Centers for Medicare and Medicaid Services (CMS) starts its recovery audit demonstration project, a three-state experiment using outside contractors to spot Medicare overpayments and underpayments.

"My understanding is that these are contractors who will look at Medicare claims and find claims which were inappropriately paid, and the monies recovered will mostly return to Medicare, but a percentage will be paid to the contractors," William Rogers, M.D., director of CMS's Physician Regulatory Issues Team, said at a meeting of the Practicing Physicians Advisory Council (PPAC). Medicare "is going to see if it's a helpful addition to our current efforts to prevent fraud," he said.

Members of PPAC, which advises Medicare on physician issues, wanted more information. "If it's going to become more widespread, I'd like to hear more about it," said Robert L. Urata, M.D., a family physician in Juneau, Alaska. CMS officials told council members that more information would be forthcoming at a future meeting.

Dr. Urata isn't the only one with questions. The American College of Physicians is apprehensive about the project. "We are concerned that the financial incentive for the contractor is to find errors and to recoup money—that whole bounty hunter approach," said Brett Baker, the ACP's director of regulatory affairs. "That may cause a lot of disruption to a lot of people who may not have billed in error but still have to go through a disruption for that decision to be made."

According to the demonstration project's "statement of work," contractors may look for both overpayments and underpayments, noncovered or incorrectly coded services, and duplicate services.

However, contractors are not to look for overpayments or underpayments that stem from miscoding of the evaluation and management service, for example, billing for a level 4 visit when the medical record only supports a level 3 visit. They are to look for incorrect payments arising from evaluation and management services that are not reasonable and necessary, and violations of Medicare's global surgery payment rules even in cases involving evaluation and management services.

Mr. Baker said ACP "appreciates the sensitivity to the complexity in selecting the level of service, since it's been demonstrated that informed and knowledgeable people can have differences of opinion on what is an appropriate level of service."

He also praised CMS for the improvements it has made in its auditing process. "Years ago, Medicare would look at a small number of claims and then extrapolate errors and say, 'You owe us $100,000.' "

Now the agency conducts an analysis of physicians' billing profiles and looks for statistical outliers. Mr. Baker said the ACP is encouraging CMS to become more sophisticated in its analysis—for example, by looking at factors such as the number of hospitalizations a particular patient has had—to see whether there might be reasons for that bill to be outside the norm. ■