Medicare Advisors Look at Outpatient Drugs

Physicians would choose one system or the other for all the drugs commonly furnished to their specialty.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

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 copays for the drugs. "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. "If you're asking if a contractor would waive coinsurance for that particular beneficiary, 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.

Dr. Castellanos pressed further. "These patients have ongoing treatments that can last for years. You're telling me that even though a patient is unable to pay coinsurance, that the contractor will bill the patient, but still has to supply the drug?" he asked.

Mr. Thompson seemed to answer in the affirmative. "We did not propose any mechanism for a contractor to deny supplying drugs to a beneficiary," he said.

Council members also wanted to make sure they could get drugs for off-label use under the new system. They recommended that CMS require contractors to provide drugs for off-label use "when the evidence supports such use." ■

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 supports only 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 own auditing process. "Years ago, Medicare would look at a small number of claims and then extrapolate errors and say, 'You owe us $100,000,' " he said. "They have since improved that process."

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.

Mr. Baker said that physicians are also concerned that the pilot program may spread to other states. "We're in the process of pulling together information on the program, which will probably result in a letter to CMS saying, 'If it's the law to do this, we want you to implement this in as fair a way as possible.' " ■

W.Va. Sees Good Signs Since Liability Reform

BY MARY ELLEN SCHNEIDER
Senior Writer

The malpractice environment may be starting to improve for physicians in one state 2 years after a comprehensive medical liability reform bill was enacted there.

"It's probably too early to see a huge improvement," said Frederick C. Blum, M.D., president-elect of the American College of Emergency Physicians. "But the signs are encouraging."

The first signs are coming from the insurance industry. Loss ratios for medical liability carriers have improved since the reform legislation was passed in 2003, according to a report from the state's insurance commissioner. The percentage of medical liability insurance premiums spent on claims and expenses in the state fell from 135% in 2002 to 107% in 2003. Ratios above 100% indicate the insurer has an underwriting loss.

The 2003 law established a $250,000 cap on noneconomic damages and set a $500,000 cap on damages for injuries sustained at trauma centers. The law also strengthened the qualifications required to be an expert witness.

Within weeks of law's passage, physicians stopped talking about leaving the state, said Steven Summer, president of the West Virginia Hospital Association. "Retention changed almost overnight."

And the malpractice insurance market has become more predictable, he said, adding that the next piece will be a reduction in physicians premiums.

One specialty hit hard by the medical liability crisis is emergency medicine. Since malpractice reform was enacted, there has been a slight uptick in the number of emergency physicians practicing in the state, according to figures from the West Virginia Board of Medicine. In 2003, 178 physicians licensed in the state designated their specialty as emergency medicine. By the end of last year, that figure had risen to 188 physicians.

But physicians aren't out of the woods yet, said Dr. Blum, also of West Virginia University.

The law is already under attack by plaintiffs' lawyers trying to get the reform declared unconstitutional by the courts. But physicians got a boost last year when a state Supreme Court justice hostile to medical liability reform lost his bid for reelection.

In addition to remaining active in state Supreme Court elections, the medical community in the state continues to push for further reforms, said Robert C. Solomon, M.D., faculty director of the emergency medicine residency at Ohio Valley Medical Center in Wheeling.

West Virginia physicians also must contend with the state's lingering image problem, Dr. Solomon said. There is still a sense that the state has a hostile medical liability environment, he said, which can hurt recruiting efforts.

"It's still on the list of danger zones," Dr. Solomon said. ■