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Lilly Oncology

Reimbursement Update

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Lilly Oncology is pleased to offer this newsletter as part of our commitment to patient access to care. For more information about the topics discussed in this issue, please contact Samantha Yu, Manager Reimbursement Consulting for AccessMED, at 650-759-6210.

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This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of the written law or regulations or local payer guidelines. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

MG52863

New Bill Makes Adjustments to Medicare Coverage and Reimbursement

Impending Reduction in Physician Fee Schedule Reimbursement Averted

The Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331)[i] was enacted on July 15, 2008, after both chambers of Congress voted to override a Presidential veto of the bill. This legislation addresses numerous issues impacting coverage and reimbursement for items and services covered under Medicare and Medicaid.

The bill eliminates the 10.6 percent reduction in physician payments that was scheduled to take place on July 1, 2008. Claims for services covered by the Medicare physician fee schedule with dates of service of July 1, 2008, through December 31, 2008, will now be paid at the same rate as claims for prior dates of service in 2008. In 2009, reimbursement rates for these services will rise by 1.1 percent.[ii]

This is a temporary fix to a significant problem in the Medicare physician fee calculation. Congress now has eighteen months to provide a permanent solution. If this is not accomplished, reimbursement beginning in 2010 could again be subject to a large reduction (20% or more by some estimates).

There are numerous other provisions of interest to physicians, pharmacies and Medicare Prescription Drug Plans in H.R. 6331. For example:

Physician Quality Reporting Initiative (PQRI): Medicare will continue to provide an incentive payment for eligible professionals who participate in PQRI. (In the absence of H.R. 6331, the incentive payment was scheduled to lapse.) The incentive payment will be 2% of total allowed charges for covered professional services billed under the Physician Fee Schedule furnished during 2009 and 2010.[iii]

As a side note, CMS has announced that PQRI incentive payments for participation during 2006 (which are being paid in mid-2007) average $600 per individual professional and $4,100 per physician group practice. The largest incentive payment to a group practice was nearly $206,000.[iv]

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Electronic Prescribing: Beginning in 2009, successful electronic prescribers of Part D drugs will be eligible for an incentive payment from Medicare. The incentive payment will be 2 percent of the allowed charges for covered professional services in 2009 and 2010; 1.5 percent in 2011 and 2012; and 0.5% in 2013. Beginning in 2012, practices who are not successful electronic prescribers may see a *reduction* in their reimbursement rates for professional services. These practices would be paid at 99 percent of the fee schedule in 2012; 98.5 percent in 2013; and 98% in 2014 and after.[v]

Advanced Diagnostic Imaging: Suppliers (including physician practices) who provide the technical component of advanced diagnostic imaging services must be accredited in order to receive Medicare payment for those services beginning January 1, 2012. CMS will conduct 2-year demonstration projects to assess the appropriate use of imaging services beginning no later than January 1, 2010.[vi]

Medicare Part D

- **Clean Claims:** Beginning in 2010, prescription drug plan sponsors will be required to pay clean electronic claims within 14 days (30 days if the claim is not electronic). If an electronic claim is deficient when it is received from a pharmacy, the PDP must notify the pharmacy within ten days of receipt (15 days if the claim is not electronic); otherwise, the claim is deemed to be a clean claim. Interest must be paid on clean claims that are not processed within these timeframes. Also, clean claims must be paid by electronic transfer of funds, and electronic remittances must be provided, if a pharmacy requests them.[vii]

- **Regular Update of Prescription Drug Pricing Standard:** Beginning in 2009, if a PDP sponsor uses a standard for reimbursement for pharmacies that is based on the cost of a drug, then the sponsor must update the standard not less frequently than once every seven days to accurately reflect the market price of acquiring the drug.[viii]

- **Drugs Mandated for Formulary Inclusion:** Currently, PDPs and Medicare Advantage PDP formularies must include all drugs in six specified therapeutic classes (anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics and immunosuppressants). Beginning in 2010, the Secretary of Health and Human Services may require the inclusion of certain other drug categories or classes on all Part D formularies when both of the following criteria are met:

  1) Restricted access to drugs in the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class

  2) There is significant clinical need for such individuals to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as drugs used in the treatment of cancer.[ix]

- **Coverage of Barbiturates:** There is currently no Part D coverage for barbiturates. Beginning in 2013, Medicare Part D will cover barbiturates used to treat epilepsy, cancer or chronic mental health disorders.[x]

CMS is expected to issue operating instructions regarding these and other provisions of the Medicare Improvements for Patients and Providers Act of 2008 as the various deadlines for implementation approach. Physicians and other health care professionals should continue to monitor the Web sites of their various Medicare Administrative Contractors for detailed guidance as it becomes available. ◆

[i] The Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331): http://thomas.loc.gov/
[ii] H.R. 6331, Section 131
[iii] H.R. 6331, Section 131
[iv] CMS Press Release, July 15, 2008:
http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3198&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

[v] H.R. 6331, Section 132
[vi] H.R. 6331, Section 135
[vii] H.R. 6331, Section 171
[viii] H.R. 6331, Section 173
[ix] H.R. 6331, Section 176
[x] H.R. 6331, Section 175

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