Medicare Recovery Audit Project Spurs Concern

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

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). Instead, 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."

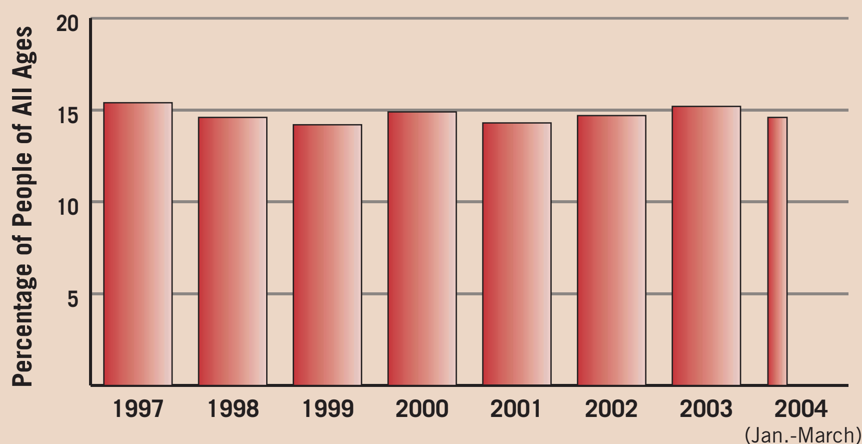
He also praised CMS for the improvements it has made in its own auditing process. "Years ago, Medicare would look at a small number of claims and then extrapolate errors and say, 'You owe us $100,000,' " he said. "They have since improved that process."

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.' "

The new program may be low risk to CMS, since it pays only if money is recovered, "but everyone has an incentive to avoid reverting back to what was a very antagonistic relationship between Medicare and the physician," he added. ■

DATA WATCH



Note: In early 2004, approximately 42 million people were uninsured in the United States.
Source: Centers for Disease Control and Prevention

RICHARD FRANKI, RESEARCH

Part D Prescription Benefit May Facilitate Formulary Appeals

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 that private plans reported having little experience with this kind of adjustment.

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.

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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 its interviews with stakeholders, MedPAC learned that prior authorization often creates burdens for both 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 out of pocket for a drug when the drug 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. ■

Discount Cards Not Created Equal

Some discount medical cards provide value, while others have serious drawbacks such as high-pressure sales tactics, exaggerated claims of savings, inaccurate promotions, or difficulty finding participating physicians, a survey from the Commonwealth Fund concluded.

The cards promise discounts for a range of providers, including physicians, hospitals, laboratory work, and surgical procedures. Some discount card companies are seeking to reform the market through a trade association and voluntary code of conduct. Because the cards aren't regulated, "legislative action is needed that gives state insurance departments the authority and resources to have direct oversight of the discount medical card industry," the authors stated.

"Uninsured individuals … are turning to discount cards to provide at least some financial protection," said Commonwealth Fund President Karen Davis in a written statement. "Some even buy cards in the mistaken belief that they are insurance plans—in part because of misleading marketing."

Researchers tested 5 of 27 cards by undergoing the application process, seeking health care services from participating providers, and then canceling the cards.

—Jennifer Silverman