

# Medicare Minutes

## Physician Voluntary Reporting Program Launched

Since January 1, 2006, physicians have been able to participate in a voluntary program of reporting on 36 evidence-based performance measures. The intent of the Physician Voluntary Reporting Program (PVRP) is to “initiate the process by which physicians who choose to participate would begin reporting quality data and be able to receive feedback on their performance, as well as to provide input on how quality reporting can be improved and made less burdensome.”

The PVRP’s most important feature, aside from its voluntary nature, is the use of claims data for quality reporting. Other physician performance reporting systems rely on retrospective chart reviews at a much greater cost and burden. CMS has created new 5-digit codes starting with the letter “G” that can be included in the claim submitted to Medicare just like CPT® codes. Eligible patients are identified through either CPT® procedure codes or ICD-9 diagnostic codes. These clinical data will then be used to measure the quality of services provided to Medicare patients. CMS anticipates that these G-codes will serve as an interim step until the submission of data through electronic health records replaces this process.

CMS will provide feedback to participating physicians by the summer of 2006 about their level of performance based on the submitted data. The goal is to use this feedback to assist physicians in improving their data accuracy, reporting rate, and clinical care. CMS will also seek input from the physicians on ways to improve the ease of reporting and usefulness of the quality measures.

Please send questions about the PVRP to [PVRP@cms.hhs.gov](mailto:PVRP@cms.hhs.gov).

## Medicare’s Implementation of the National Provider Identifier

All health care providers, including Medicare providers should apply for their new National Provider Identifier (NPI) as soon as it is practicable to do so by going to <https://cms.hhs.gov> on the Web. The objective of the proposed NPI system is to assign a unique national identifier number to each and every provider of Medicare health care services. This includes physicians, nurses, nurse practitioners, dentists, pharmacists, physical therapists, physician group practices, acute care hospitals, long-term care facilities, outpatient facilities, nursing home facilities, hospices, home health agencies, ambulance service providers, clinical laboratories, durable medical suppliers, health maintenance organizations, pharmacies, and more. This number will eventually eliminate the need for multiple provider numbers for single provider PIN and UPIN numbers, as well as the utilization of DEA numbers as an identifier for standard provider transactions.

The following schedule will be implemented for the use of the NPI in Medicare billing:

- **January 3, 2006—October 1, 2006**

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI.

Medicare will be capable of sending the NPI as a primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

- **October 2, 2006—May 22, 2007**

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider’s NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and*

*billings services continue to submit the Medicare legacy identifier as a secondary identifier.*

Medicare will be capable of sending the NPI as a primary provider identifier *and* legacy identifier as a secondary identifier in outbound claims, claim status responses, remittance advice (electronic but not paper), and eligibility response electronic transactions.

- *May 23, 2007—Forward*

CMS systems will only accept NPI numbers. Small health plans have until May 23, 2008 to be NPI compliant.

For information regarding the National Provider Identifier visit the Academy Web site at <http://www.aanp.org>. Click first on regulation and then on National Provider Identifier.

## Exceptions and Appeals Process for Part D Claims

As part of the new Medicare prescription drug benefit, CMS has developed exceptions procedures designed to ensure that enrollees receive prompt decisions regarding whether drugs are medically necessary. Physicians will play an important role in the process, as they will be responsible for providing proof of medical necessity on behalf of their patients. Following are frequently asked questions and answers and a summary chart to help clarify the appeals process for Part D claims.

### Exceptions Process

**Q:** *My patient has been stabilized on a drug that is not on the plan's formulary that they joined. Can my patient still get the drug while I evaluate other options?*

**A:** Yes. Medicare PDPs are required to have an appropriate transition process when the patient has been stabilized on a medication at the time they join the plan. This transition process differs from plan to plan, and you or the patient's pharmacist may have to contact the plan for additional information. Plans must also provide coverage for all, or substantially all, drugs in the following drug categories: antidepressants, antipsychotics, anticonvulsants, an-

tirerovirals, immunosuppressants, and anti-neoplastics.

**Q:** *What needs to be done if a medically necessary drug is not on a PDP's formulary or requires prior authorization?*

**A:** The prescriber always has a choice to change the prescription to another medically appropriate medication that is covered by the PDP. However, drug plans must provide an exception/appeal process for drugs not on their formulary. To file an exception or appeal, contact the patient's plan. If a beneficiary has a prescription for a drug that requires prior authorization, the PDP must also be contacted.

**Q:** *How long does it take for a plan to make a decision on my exception request?*

**A:** An expedited exception requires the plan to make a decision within 24 hours or less, depending on the patient's medical condition. Only the prescriber can request an expedited exception. If an expedited exception is not requested, the plan has 72 hours to make a determination.

**Q:** *Who notifies the provider and beneficiary about the requirements of the PDP appeal process and the outcomes of any reconsiderations or exceptions?*

**A:** A plan must provide their enrollees with information regarding their specific exception and appeals process. It is likely that you or your patient will need to contact the plan to find out the specific requirements and forms in order to submit an exception request. Pharmacies are also required to provide general written information on how a recipient can request an exception and appeal.

In general, the plan is responsible for notifying the provider and beneficiary of the outcomes of exception and appeal requests. All negative decisions must be provided in writing to the beneficiary.

**Q:** *What if a Medicare PDP denies a prior authorization or an exception request?*

**A:** Medicaid will provide a limited "wrap-around" benefit for drugs not covered under

**Table 1.**  
**Appeals Process for Part D Claims**

		<b>Routine Appeal</b>	<b>Urgent Appeal</b>
1	Redetermined by Part D plan	If the Part D plan's initial coverage determination is unfavorable, an enrollee may request a redetermination and the plan has up to 7 days to make its decision.	Same as standard, except the plan must make its decision within 72 hours.
2	Reconsideration by an Independent Review Entity (IRE)	If the Part D plan's redetermination is unfavorable, an enrollee may request reconsideration by an IRE, which is a CMS contractor that reviews determinations made by a plan. The IRE has up to 7 days to make its decision.	Same as standard, except the IRE must make its decision within 72 hours.
3	Administrative Law Judge (ALJ)	If the IRE's reconsideration is unfavorable, an enrollee may request a hearing with an ALJ if the amount in controversy is satisfied.	Not applicable.
4	Medicare Appeals Council (MAC)	If the ALJ's reconsideration is unfavorable, an enrollee may appeal to the MAC, an entity within the Department of Health & Human Services that reviews ALJ's decisions.	Not applicable.
5	Federal District Court	If the MAC's decision is unfavorable, an enrollee may appeal to a Federal District Court if the amount in controversy is satisfied.	Not applicable.

the PDP, but only after the prescriber has requested an exception from the Medicare drug plan and has received a denial.

**Q:** *Can Medicaid cover my patient's drug if the exception request was denied by my patient's plan?*

**A:** Medicaid will pay for a drug only after the prescriber has requested an exception request from the PDP, provided the appropriate medical justification, and was denied by the plan. The prescriber can call the Medicare Verification System (MVS) and receive an MVS number, which is written on the prescription. The pharmacist will use this number when calling

the MVS, and will respond to a short series of questions before billing Medicaid for the prescription.

He or she will need to decide whether another drug covered by the beneficiary's PDP can meet the patient's medical need. If so, a new prescription for the covered drug can be written and no additional action is needed. Otherwise, the prescriber will need to file an exception or appeal request by contacting the beneficiary's plan. Be prepared to provide medical justification for your request.

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### Part D Fraud and Abuse: PDPs Will Be Key to Detection

Opportunities for fraud in the new Medicare Part D prescription drug program exist and will become more frequent as the benefit continues to gather momentum. At the same time, federal compliance program requirements will be taking effect for the prescription drug plans (PDPs), and CMS is prepared to fight fraud and abuse with the hiring of Medicare Integrity Drug Contractors (MEDICs) to oversee the audits of PDPs required under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). These contractors have specialized skill sets that enable them to detect fraud, waste, and abuse, now to be known as “FWA” in the new prescription drug program.

Plans that offer the drug benefit also are required to have in place programs to detect, prevent, and correct FWAs. Although the vast majority of PDPs have subcontracted with pharmacy benefit managers (PBMs) to administer the benefit, CMS has made it clear that the PDP will be held responsible for violations, even for an FWA at the PBM or network pharmacy level. It is CMS' expectation that PDPs will self-report fraud to the federal government. The MMA specifically requires that the PDP compliance plan “*should include procedures to voluntarily self-report potential fraud or misconduct related to the Part D program to the appropriate government authority.*”

The Office of the Inspector General (OIG) will look at relationships PDPs have with drug manufacturers, wholesalers, and pharmacies. It is expected that the OIG will get cases for possible investigation both from False Claims Act relators who see Part D problems and from CMS referrals. Examples of the types of complaints to be investigated may be found on the Health Integrity's Web site (<http://www.healthintegrity.org/index.html>), by calling (877)7SafeRx (1-877-772-3379), or by faxing (410-819-8698). **MPM**

## Case Study

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poor adherence—and do everything possible to get them to do what is best. However, when resistance affects adherence and results in MRPs, it will be important for the patient's physician and family members to support participation in a plan in which medications are administered by facility staff.

### What's the Cost?

How much such a medication management system would cost is a serious concern for many patients. Strickland admitted that good systems can be costly to implement and utilize. Approximately 75% of pharmacies currently charge an average of \$15 to \$20 per patient for packaging this type of system. She suggested that facilities work with pharmacy providers to get them to support or share the system's cost in return for increased business or status as a result of being a facility's or health system's preferred provider.

Currently, neither Medicare nor Medicaid pays for medication management systems. Likewise, they will not be covered under the new Medicare prescription drug benefit. However, the details of the medication therapy management services (MTMS) component of the benefit have yet to be worked out, and there is a possibility that such systems could be covered for high-risk patients taking a large number of prescriptions.

Nonetheless, Strickland insisted that even if the facility has to foot the bill itself, a good medication management system pays for itself in short order. In her study, adherence increased and MRPs and related hospitalizations decreased significantly.

The money these systems save in terms of reduced medication errors is only part of the equation, she suggests. Fewer medication errors generally mean that seniors remain functional longer and have a better quality of life. And that, she stressed, is an important goal in any aspect of senior care. **MPM**

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