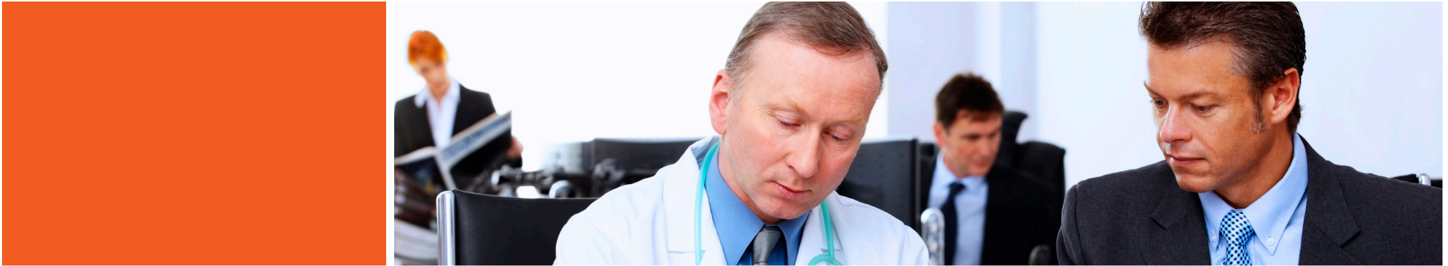
NOVARTIS OPM
NEWSLETTER

Quarterly Health Policy Updates for Novartis Oncology Practice Managers

JULY 2010



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Note:
These updates are provided to you as an informational reference as a Novartis Oncology OPM speaker

CMS Reduces Medicare Claims Filing Deadline

On May 7, 2010, the Centers for Medicare & Medicaid Services (CMS) announced updates to its filing deadline for claims that are submitted for services rendered under Medicare Parts A and B. Specifically, per the Patient Protection and Affordable Care Act (PPACA), CMS reduced its timely claim filing deadline from 18 months to no more than 12 months.

Prior to PPACA, the claim filing deadline for services rendered was structured as follows:[1]

- Services rendered during the first nine months of the calendar year would need to be submitted on or before the end of the following calendar year
- Services rendered during the last three months of the calendar year would need to be submitted on or before the end of the second following calendar year

Under the new filing deadline per PPACA, any claim which is more than one year old will be denied by Medicare contractors. Specifically, the following timelines will be enacted:[1]

- Claims with dates of services prior to October 1, 2009 will not be subject to the 12 month claims filing deadline
- Claims with dates of services between October 1, 2009 and December 31, 2009 will be denied if they are submitted for processing after December 31, 2010
- Claims with date of service January 1, 2010 and later which are received more than one calendar year past the date of service will be denied

1. http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf

With the new Medicare filing deadline structures, oncology practices should consider conducting a comprehensive assessment of Medicare claims tracking and monitoring as well, as ensuring that there is a procedure set-up to do so. With these recent changes, oncology practices may want to check for claims with dates of services in 2009, which have not yet been submitted and determine appropriate processing. Lastly, all billing staff should also be receiving up-to-date communication about the changes in Medicare deadline structures and filing claims accordingly.

For more information, you can review the Medicare Network Learning document on the topic by clicking on the following link: **http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf**

Understanding the Medicare Part D Coverage Gap Discount Program

Under the Patient Protection and Affordable Care Act (PPACA), the Medicare Coverage Gap Discount Program was established.

Beginning in June this year, this program will provide a rebate of $250 to Medicare Part D beneficiaries who reach the coverage gap, or “donut hole.” In 2011,Medicare beneficiaries will be provided with manufacturer-sponsored discounts of 50% towards brand-name drugs while in the coverage gap. Medicare Part D beneficiaries can receive these discounts at the point of sale, whether at a retail pharmacy of specialty pharmacy – no action is required from the patients. While manufacturer involvement in the Medicare Part D Coverage Gap Discount Program is not mandatory in 2011, it is expected that most manufacturers will participate.[2]

Over time, subsidies from Medicare will be phased in (for generic drugs beginning in 2011 and for brand-name drugs in 2013), which will reduce the benefit coinsurance rate in the coverage from 100% to 25% by 2020. Between 2014 and 2019, the law will further reduce the out-of-pocket amount necessary for Medicare Part D beneficiaries to obtain catastrophic coverage.[2]

Ultimately, the goal of the Medicare Coverage Gap Discount Program is to close the coverage gap and decrease patient responsibility of cost-sharing prior to the catastrophic coverage phase. With the phase out of this program and multiple adjustments expected over the next 10 years, it will be particularly important for oncology practices to monitor and understand these changes as well as their impact so that they can be prepared to respond to patient questions and needs.

2. http://www.kff.org/healthreform/upload/8059.pdf

Preparing for Questions Posed by Your Patients on Healthcare Reform

With the technical complexities of healthcare reform legislation, as well as its implementation, many of your patients may come to you with questions in which they want to know in simple terms if and how the law may affect access to their oncology care and treatments. To assist, a list of anticipated questions which patients may pose and easy-to-understand answers that you can consider providing is provided below.[3]

When do I really have to start worrying about all of this reform in healthcare?[4]

Many of changes from healthcare reform won't go into effect until 2014. If by 2014, the law isn't significantly amended or repealed, the government will ensure that insurance is more affordable for a millions of people, so they can better access the medical care they need.

Some changes will occur before 2014 though. For example, later this year in 2010, insurance companies won't be able to deny coverage to children if they have pre-existing conditions or become ill. Dependent children can also stay on their parent's insurance until they are 26 years old. Starting this year, the Medicare Coverage Gap Discount Program will provide a rebate of $250 to Medicare Part D beneficiaries who reach the coverage gap. Between 2011 and 2014, much of the behind-the-scenes work will be going on, especially with tightening restrictions on private insurers, boosting primary care, and enhancing coverage of preventive care.

Will I lose some of my Medicare or Medicaid benefits?[3]

Healthcare reform is looking to expand coverage, not take away your benefits. Starting in 2010, Medicare will begin to close its coverage gap, which will be completed by 2020. In addition, Medicare start with not requiring beneficiaries to pay for certain recommended screenings such as cholesterol and cancer tests. For Medicaid, the program is going through a major expansion. In fact, starting in 2014, Medicaid benefits can be used by anyone who has an income at 133% of poverty or lower – in other words, about $14,000 for an individual or $29,000 for a family of four.

Is healthcare going to be rationed, or will I still be able to get the tests and procedures I need for my care?[5]

Healthcare reform will place medical decision-making in the hands of healthcare providers and patients – your healthcare will not be rationed.

In addition, measures will be put in place to ensure that patients will not be let go from your insurance for being "too sick" or be denied coverage due to an already existing condition.

3. Adapted from "Health reform questions: your patients will ask, here are some answers" (written by David Glendinning) from amanews.
4. http://www.ama-assn.org/amednews/2010/05/31/gvsa0531.htm
5. http://www.whitehouse.gov/realitycheck/faq#s2

Healthcare reform will also work on changing the way that healthcare providers are compensated. Currently, providers are paid per procedure quantity, not on the quality of their performance during that procedure. With healthcare reform, the focus will shift from quantity and center more on quality.

How much more will I be paying into the system to allow for 'coverage for all'?[3]

Individuals who make more than $200,000 a year and couples who earn more than $250,000 annually will pay more into the Medicare system. Specifically, patients who fall into either of these categories, may expect to see their Medicare payroll taxes increase from 1.45% to 2.35% in 2013 – the year prior to when most of the healthcare reform expansions will become effective.

When it comes to figuring out if there will be an increase in a beneficiary's deductible, premium or co-pay – this has yet to be determined. Insurance plans will be covering many more individuals so the effect on specific plans will be mapped out sometime down the road.

CMS Releases Third Quarter 2010 ASP Payment Rates

On June 18, 2010, CMS released the third quarter 2010 Average Sales Price (ASP)-based rates for physician-administered drugs. Specifically, these rates reflect the actual Medicare allowables that will be utilized to pay for most Part B covered drugs administered in the physician-office setting for the third quarter of 2010 (effective July 1, 2010 through September 30, 2010).[6] To access the complete ASP drug pricing file, please use the following link on the CMS website: **www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a19_2010aspfiles.asp#TopOfPage**

Medicare allowables for most Part B drugs used in the physician office setting are based on 106 percent of ASP, which CMS calculates from the sales data submitted by drug manufacturers. Each quarter, manufacturers provide updated sales data to CMS, which then results in a quarter-to-quarter change in drug pricing. In this latest release, the payment allowance limits for most products are based on first quarter 2010 ASP data submitted by manufacturers, creating a two-quarter lag between data submission and ASP calculation.

In its third quarter 2010 ASP release, CMS stated that average drug prices between second and third quarter 2010 generally remained stable in the market. In addition, CMS explained that "on average, prices for the top part B drugs increased by 0.7%. For most of the higher volume drugs (31 out of the top 50), the prices changed 2 percent or less."[6] Similar to recent ASP releases, CMS explained that for the top products that saw a decrease in pricing, "there are a number of competitive market factors at work – multiple manufacturers, alternative therapies, new products, recent generic entrants, or market shifts to lower priced products."[6] CMS will continue to monitor trends in pricing as reflected by the published ASP payment

rates and product utilization within the Medicare community to ensure continued beneficiary access to Part B covered drugs.[6]

To demonstrate the variances between second quarter 2010 and third quarter 2010 drug payment, Xcenda analyzed the change in ASP for the ten drugs and biologicals with the highest expenditures, as published by Medicare in 2008.[7] In Table 1 below, the drugs and biologicals and the change in payment from second quarter 2010 and third quarter 2010 are listed.

Table 1. Medicare ASP Drug Payment for Select Products, Q2 2010 vs. Q3 2010[6]

HCPCS Code	Description	Q2 2010 ASP	Q3 2010 ASP	Percent Change Q2 vs. Q3
J9310	Rituximab injection, 100 MG	$ 578.402	$ 579.210	0.13%
J2778	Ranibizumab injection, 0.1 MG	$ 404.697	$ 405.066	0.09%
J9035	Bevacizumab injection, 10 MG	$ 57.569	$ 58.446	1.52%
J1745	Infliximab injection, 10 MG	$ 58.740	$ 58.587	-0.26%
J2505	Injection, pegfilgrastim, 6MG	$ 2432.499	$ 2470.743	1.57%
J0881	Darbepoetin alfa, non-esrd, 1MCG	$ 2.880	$ 2.967	3.02%
J0885	Epoetin alfa, non-esrd, 1000 UNITS	$ 9.442	$ 9.663	2.34%
J9263	Oxaliplatin, 0.5 MG	$ 6.825	$ 4.462	-34.62%
J7626	Budesonide non-comp unit, 0.5 MG	$ 6.424	$ 4.853	-24.45%
J7507	Tacrolimus oral, 1 MG	$3.293	$3.327	1.032%

As outlined in Table 1, among the drugs and biologicals analyzed, most experienced very slight changes in payment rates of approximately two percent or less, from second quarter 2010 to third quarter 2010. Overall, most of the drugs outlined experienced increases in ASP-payment, except for J9263 (oxaliplatin) which decreased by 34.62 percent, J7626 (budesonide non-comp unit) which decreased by 24.45 percent, and J1745 (infliximab injection) which decreased by 0.26 percent.

Because variability in drug payments can provide challenges for oncology practices, it is important to monitor changes carefully and regularly, and update systems appropriately.

6. http://www.cms.gov/McrPartBDrugAvgSalesPrice/01a19_2010aspfiles.asp
7. http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/Level2CHARG08.pdf

AMA Study Shows that 1 in 5 Claims are Incorrectly Processed by Commercial Payers

On June 14, 2010, the American Medical Association (AMA), released its third annual 2010 National Health Insurance Report Card (NHIRC), in which the country's largest doctor group reviews its assessment on national commercial insurers. As a key finding in the assessment, the AMA reports that "one in five medical claims is processed inaccurately by commercial health insurers," marking significant implications for incorrect payment and related administrative challenges for oncology practice management.

Unlike prior years, the 2010 NHIRC study focuses primarily on national commercial insurers, although some assessment of Medicare is also included. Specifically, this year's report card reviews claims processing across the following commercial insurers:[8]

- Aetna Inc.
- Anthem Blue Cross Blue Shield
- Cigna
- United Health Group
- Humana, Inc.
- Health Care Service Corp.
- Coventry Health Care

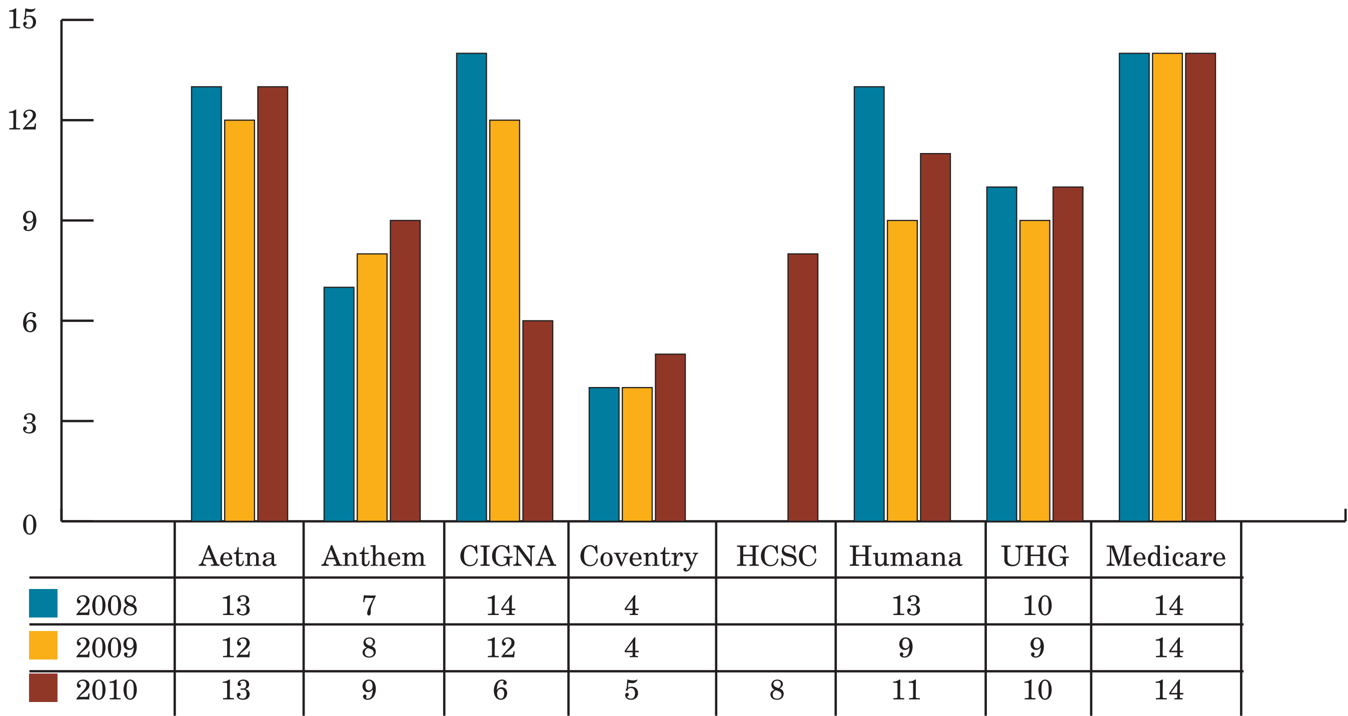
When assessing these seven insurers, the AMA utilized 17 metrics, which came under the following five major categories of comparison:[8]

- Payment Timeliness and Type
- Accuracy
- Claim Edit Sources and Frequency
- Denials
- Improvement of Claims Cycle Workflow

In studying these metrics across the noted insurers, the AMA found that claim response time range from 5 to 13 days, with an overall accurate rate measuring at 80%. Of these insurers, Coventry Health Care ranked the highest with a national accurate rating of 88.41%, while Anthem Blue Cross Blue Shield ranked the lowest with a national accurate rating of 73.98%.[8] Graphs 1 and 2 below provide additional details.

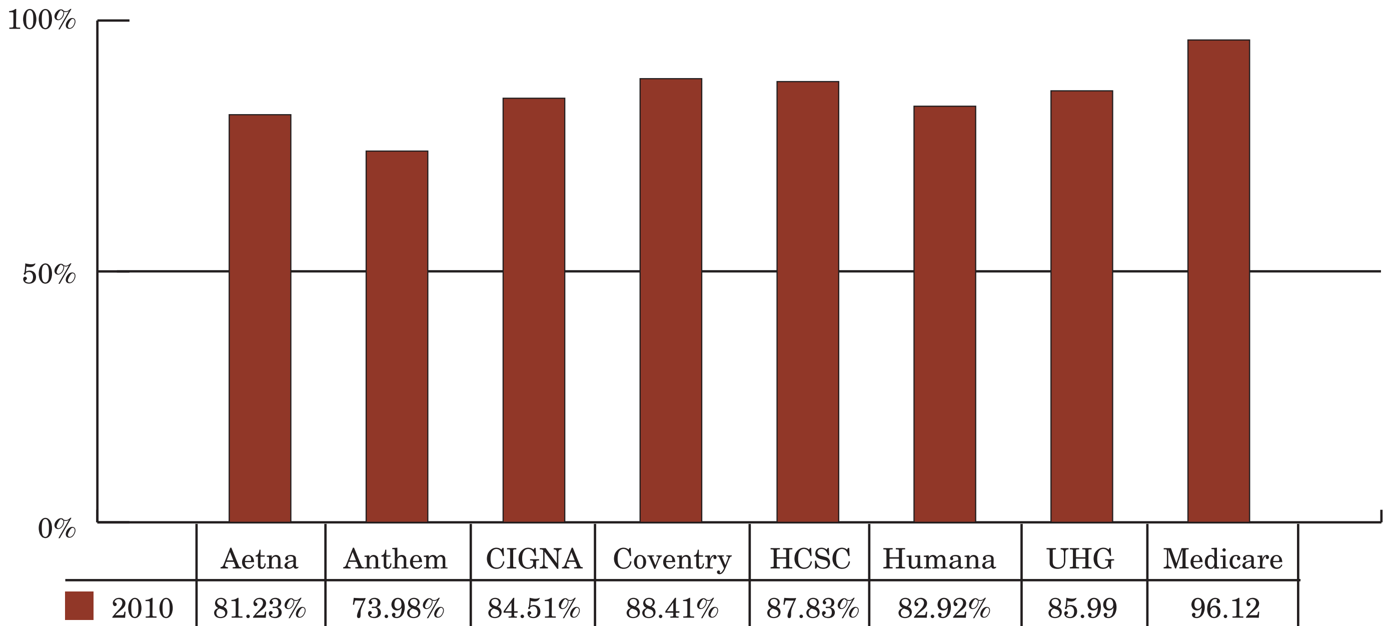
8. http://www.ama-assn.org/ama/pub/news/news/2010-report-card.shtml
9. http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/heal-claims-process/national-health-insurer-report-card/payment-timeliness.shtml

GRAPH 1. Payment Timeliness (First Remittance Response Time in Median Days)[9]



	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
2008	13	7	14	4		13	10	14
2009	12	8	12	4		9	9	14
2010	13	9	6	5	8	11	10	14

GRAPH 2. Payment Accuracy (Electronic Remittance Advice Accuracy)[10]



	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
2010	81.23%	73.98%	84.51%	88.41%	87.83%	82.92%	85.99	96.12

* = New metric reported in 2010 NHIRC
** = May not total 100% due to rounding error
BCBS = Blue Cross and Blue Shield
DNR = Payer did not respond
HCSC = Health Care Services Corporation
UHG = UnitedHealthcare Group

10. http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/heal-claims-process/national-health-insurer-report-card/accuracy.shtml

Currently, the healthcare system spends approximately $210 billion on claims processing annually, which the AMA estimates could be cut down by $777.6 million in administrative costs per year, if the insurance industry could improve its claims processing accuracy ratings by just 1%. In the existing system, each health insurer employs different claims payment and processing procedures, which exacerbates the lack of efficiencies. In its press release, the AMA cites a recent study which found that "to keep up with the administrative tasks required by health plans, physicians divert as much as 14% of their revenue to ensure accurate payments from insurers."[7] Overall, the study estimates that the physicians spend time equivalent to five weeks per year in managing red tape associated with health insurers.[8]

According to Nancy H. Nielsen, M.D., the AMA Immediate Past President, "The finding that one in five medical claims is processed by insurers with errors emphasizes the huge potential for reducing administrative costs for physicians and insurers…Simplifying the administrative process with standardized requirements will reduce unnecessary costs in the health system and eliminate the variability that makes it necessary for physicians to maintain costly claims management systems for each health insurer."[8]

With the passage of comprehensive healthcare reform earlier this year, the law now requires that health insurers implement administrative simplification which is meant to ease the current burden and challenges posed by claims processing and other issues. Provisions related to such legislation will be issued by July 1, 2011.

Until then, given the current high percentage of incorrectly processed claims, oncology practices should implement tracking procedures to ensure the accuracy both for submitted claims that are approved, as well as those denied.

For support with claims assistance, please call the Novartis Oncology Reimbursement Hotline at 800.282.7630 (Monday – Friday, 9:00AM – 8:00PM EST) or visit our website at **http://www.novartisoncology.us.**

For online resources on claims preparation, progress monitoring, and appealing tools, please visit the AMA's Practice Management Center website at **http://www.ama-assn.org/go/pmc.**

To access the 2010 NHIRC, please use the following link: **http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/heal-claims-process/national-health-insurer-report-card.shtml.**

RAC Contractor Connolly Healthcare Issues Approved Audit on Zometa® (zoledronic acid)

With the passage of healthcare reform, CMS continues to combat improper payments and fraud through its Recovery Audit Contractor (RAC) program.

Recently, Connolly Healthcare, the RAC contractor for Region C, posted an approved audit on units billed for Zometa when administered in the hospital outpatient site of care. RAC Region C includes the following states: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico,

North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, and West Virginia.

Specifically, this audit is concerned with reviewing billing units (and not medical necessity) for dates of service associated with Zometa beginning on October 1, 2007. Per Connolly Healthcare, "... [Zometa's J-code] represents 1mg per unit and should be billed one (1) unit for every 1mg per patient. Claims for J3487 should be submitted so that the billed units represent the administered units, not the total number of milligrams. Zometa is given as a single 4mg injection and the number of units billed on a claim should be 4."[11]

When an audit is requested consider the following recommendations:

- Organize internal resources to respond to the audit RAC request (i.e. compiling records, tracking, monitoring, dedicated staff)
- Understand and review the allowable timeframes for responding to the audit RAC request
- Ensure that the audited RAC request is within prescribed protocols (i.e. allowed number of medical records requested based on practice size)
- Review internal tracking system of records requested for RAC audit (i.e. status of patient record through the RAC review process)
- Understand the appeals processes, if appropriate

For questions regarding the Zometa audit, please call the Novartis Oncology Reimbursement Hotline at 800.282.7630 (Monday – Friday, 9:00AM – 8:00PM EST) or visit our website at **http://www.novartisoncology.us.**

To access information regarding Connolly Healthcare's audit on Zometa, please use the following link: **http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx**

11. http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

Xcenda will continue to monitor related updates. For any questions or more information, please contact Xcenda at (800)788-9637 ext. 6259.

Notice: This update is provided to you as a reference in your capacity as a Novartis Oncology OPM speaker. Please note that this update is presented for informational purposes on ly and is not intended to provide reimbursement or legal advice and should not be relied upon in that regard. Regulations and policies concerning reimbursement are a rapidly changing area. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. This update should not be used as a substitute for competent legal advice from a licensed professional attorney. Please consult with your legal counsel for any specific legal analysis on this issue.