This information is provided for your background education and is not intended to serve as guidance for specific coding, billing, and claims submissions. The decision on which codes best describe the services provided must be made by the individual providers based on specific payor guidance and requirements.
Discussion Topics

• Review reimbursement fundamentals
  – Special considerations by site of service
• Examine medical benefit (Part B) vs. pharmacy benefit (Part D)
• Examine Medicare Part B and Part D coverage
Site of Care and Payor Are Important to Reimbursement

- A patient’s healthcare coverage and site of care for treatment drive reimbursement of services and products
- Understanding how differences in payors and site of care affect reimbursement is critical

**Payor**
- Medicare
- Medicaid
- Private payor

**Site of Care**
- Hospital inpatient
- Hospital outpatient
- Physician office
- Home infusion

**Reimbursement**
Payors determine which treatments or other services their health plans will pay for based on a variety of factors including clinical efficacy, cost, plan benefit design, etc. Procedures, drugs, and diagnoses are translated into codes to be reported on a claim form—these codes tell insurance companies what services were rendered. Insurance companies review claims for medical necessity and accuracy, and determine whether to issue payment to health care providers based on a variety of reimbursement methodologies.
Select Medicare Reimbursement Systems

**Hospital Inpatient - Inpatient Prospective Payment System (IPPS)**
- Each case is categorized into a Medicare-severity diagnosis-related group (MS-DRG)
- Each MS-DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that MS-DRG

**Hospital Outpatient - Outpatient Prospective Payment System (OPPS)**
- All services are classified into groups called Ambulatory Payment Classifications or APCs
- Services in each APC are similar clinically and in terms of the resources they require
- A payment rate is established for each APC

**Physician Office - Physician Fee Schedule (PFS)**
- Reflecting national uniform relative value units (RVUs) based on the relative resources used in furnishing a service
- A payment rate is established for each CPT® code (adjusted geographically)

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* MS-DRG- Medicare Severity Diagnosis Related Group

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Part B Medical Benefit vs. Part D Pharmacy Benefit

Coverage for physician-administered drugs typically falls under Medicare Part B

<table>
<thead>
<tr>
<th>Medical Benefit - Medicare Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician orders drug from a distributor</td>
</tr>
<tr>
<td>• Distributor ships drug to the facility or physician’s office</td>
</tr>
<tr>
<td>• Physician administers drug to patient</td>
</tr>
<tr>
<td>• Physician submits claim to payor for service(s) and drug</td>
</tr>
<tr>
<td>• Physician pays distributor for drug within payment terms</td>
</tr>
</tbody>
</table>
Part B Medical Benefit vs. Part D Pharmacy Benefit (continued)

Coverage for oral and self-administered drugs typically falls under Medicare Part D

<table>
<thead>
<tr>
<th>Pharmacy Benefit - Medicare Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician writes prescription (Rx)</td>
</tr>
<tr>
<td>• Physician or patient submits Rx to pharmacy</td>
</tr>
<tr>
<td>• Patient picks up prescription at pharmacy or pharmacy may send it directly to physician, at the request of the physician</td>
</tr>
<tr>
<td>• Patient takes medication or brings the medication to physician office for administration, if needed</td>
</tr>
<tr>
<td>• Dispensing pharmacy submits claim to payor for drug</td>
</tr>
<tr>
<td>• If needed, physician administers drug to patient and submits claim to payor for administration service</td>
</tr>
</tbody>
</table>
Comparison of Benefits

**Part B**
- Covers physician administered drugs with a few exceptions
- No prior authorization
- 20% of allowable, after deductible*
- Buy and bill
- Physician bills for both the drug and administration

**Drug Coverage**

**Part D**
- Covers self administered, oral and some physician administered drugs
- Varies by plan
- Varies by plan
- Pharmacy or specialty pharmacy
- Pharmacy bills for drug

*Some beneficiaries have a secondary source of insurance that minimizes cost-share obligations under Medicare Part B.*
MEDICARE PART B

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Medicare Part B Drug Coverage

• Includes drugs that are furnished “incident to” a physician’s service in cases where the drugs are not usually self-administered by the patients.

• Generally, drugs and biologicals are covered only if all of the following requirements are met:
  – They meet the definition of drugs or biologicals
  – They are of the type that are not usually self-administered
  – They meet all the general requirements for coverage of items as incident to a physician’s services
  – They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice
  – They are not excluded as noncovered immunizations
  – They have not been determined by the FDA to be less than effective

• Contact your local Part B contractor for local coverage information

Medicare Part B Payment – Physician Fee Schedule (PFS)

- Individual physician payments vary by procedure performed
- Allowable amounts vary by locality
- Medicare pays 80% of allowable; beneficiary (or secondary insurer) pays remaining 20% coinsurance

<table>
<thead>
<tr>
<th>CPT® 1</th>
<th>Description</th>
<th>2013 MPFS National Unadjusted Payment Amount²</th>
</tr>
</thead>
<tbody>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</td>
<td>$25.86</td>
</tr>
<tr>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; non-hormonal and anti-neoplastic</td>
<td>$75.87</td>
</tr>
</tbody>
</table>

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2. Xcenda calculation of non-facility national average payment rate using 2013 RVU file (01/04/13) and conversion factor $34.0230
Sources of Supplemental or Alternative Coverage Among Medicare Beneficiaries

Approximately 93% of Medicare beneficiaries have some form of supplemental insurance that may assist with their Part B deductible or co-insurance or participate in Medicare Advantage.

Medicare Part B Payment – Drugs in Physician Office¹

• Drug Reimbursement is Average Sales Price (ASP) + 6% in 2013
  – Wholesale Acquisition Cost (WAC) + 6% (or invoice pricing) for newly-approved products if administered in the physician office setting
  – ASP + 6% once ASP is established
  – Updated quarterly based on manufacturer-submitted data

• Manufacturer’s must calculate the ASP every calendar quarter and submit it to CMS within 30 days after the close of the quarter²

• As a result, there is a two-quarter lag between ASP-submission and reflection of sales data in the Medicare payment amounts²
  – Eg, Q3 2013 Medicare payment amounts are based on Q1 2013 sales data

Coding for Physician-Administered Drugs

• Drugs are typically reported using product-specific HCPCS codes (eg, J-codes) assigned by CMS
• Drugs without an assigned J-code are reported using a miscellaneous code, such as:
  – J3490 – Unclassified Drug
  – J3590 – Unclassified Biologic
  – J9999 – NOC, antineoplastic drugs
Medicare Part D

- Comprehensive prescription drug benefit under Medicare
  - Effective January 1, 2006
  - Created by the Medicare Modernization Act of 2003
- Part D typically provides coverage for self-administered and oral prescription drugs
- Part D Plans are administered by private organizations
- Two benefit structures

<table>
<thead>
<tr>
<th>Prescription Drug Plan (PDP) (Stand-Alone Plan)</th>
<th>Medicare Advantage Prescription Drug Plans (MA-PD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Part D plan option for Medicare beneficiaries in addition to traditional fee-for-service Medicare</td>
<td>• Part D plan option for Medicare beneficiaries with Medicare Advantage plans (Part C) that cover Medicare services and prescription drugs</td>
</tr>
</tbody>
</table>

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Prescription Drug Plans (PDPs)

34 PDP Regions\(^1\)

Provides drug benefits only

26 MA-PPO Regions\(^2\)

MA-PD plans provide both Part B and Part D benefits

Contracted Sponsors

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Review of Required Covered Drugs

• CMS requires that “all” or “substantially all” drugs from the following six drug classes be included in all Part D plan formularies:
  – Antidepressant
  – Immunosuppressant
  – Antiretroviral
  – Antipsychotic
  – Antineoplastic
  – Anticonvulsant

• Drugs included in these six categories may be subject to formulary management techniques like prior authorization and step therapy.

• Per the healthcare reform legislation, these six classes were written into law and made permanent in 2011.
  – CMS has the authority to edit or establish additional categories and classes of drugs that are of “clinical concern” in the future through rulemaking.

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2013 Part D Payment Overview

• In 2013, a beneficiary’s true out-of-pocket (TrOOP) expense with a standard Part D plan includes:
  – $325 deductible
  – 25% co-insurance up to $2,970 in total drug costs

• This is followed by the gap in coverage or so-called “doughnut hole”
  – The beneficiary pays 47.5% of his or her brand prescription drug costs up to the out-of-pocket threshold of $4,750
  – Manufacturers provide a 50% discount for brand name drugs through the coverage gap

• After the coverage gap, the enrollee enters what is commonly referred to as “catastrophic coverage” where:
  – The beneficiary pays 5% of drug costs

• While this outlines the “standard” benefit, the majority of Part D enrollees choose to select a Part D plan with a different plan design, for example, a plan with a higher monthly premium but no deductible. Some plans may offer generic drug coverage in the “gap”

Example of TrOOP1

Scenario: Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. She doesn’t qualify for extra help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium – Ms. Smith Pays a monthly premium throughout the year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Smith pays the first $325 of her drug costs before her plan starts to pay its share.</td>
<td>Ms. Smith pays a 25% co-payment, and her plan pays its share for each covered drug until what they both pay (plus the deductible) reaches $2,970.</td>
<td>Once Ms. Smith and her plan have spent $2,970 for covered drugs, she is in the coverage gap. In 2013, she pays 47.5% of covered brand-name prescription drugs that counts as out-of-pocket (OOP) spending, and helps her get out of the coverage gap.</td>
<td>Once Ms. Smith has spent $4,750 OOP for the year, her coverage gap ends. Now she only pays a small copayment of 5% for each drug until the end of the year.</td>
</tr>
</tbody>
</table>

Note: If the patients get “Extra Help” paying their drug costs via the Low Income Subsidy (LIS) program, they will not have a coverage gap and will pay only a small copayment (if any) once they reach catastrophic coverage.

## 2013 Part D Low-Income Subsidy (LIS)\(^1\)

<table>
<thead>
<tr>
<th>Income</th>
<th>≤100% FPL</th>
<th>&lt;135% FPL</th>
<th>&lt;150% FPL</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asset Test(^2)</strong></td>
<td>None</td>
<td>$6,940 single&lt;br&gt;$10,410 couple&lt;br&gt;(No asset test if beneficiary is an SSI recipient or participates in Medicare Savings Programs)</td>
<td>Sliding scale: $6,941-$11,570 single&lt;br&gt;$10,441-$23,120 couple</td>
<td>None</td>
</tr>
<tr>
<td><strong>Premium(^3)</strong></td>
<td>Fully subsidized</td>
<td>Fully subsidized</td>
<td>Sliding scale</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>Fully subsidized</td>
<td>Fully subsidized</td>
<td>$66</td>
<td>$325</td>
</tr>
<tr>
<td><strong>Patient co-pay/coinsurance</strong></td>
<td>$1.15 generic&lt;br&gt;$3.50 brand</td>
<td>$2.65 generic&lt;br&gt;$6.60 brand</td>
<td>15% up to catastrophic limit</td>
<td>25% up to $661.25 in drug expense</td>
</tr>
<tr>
<td><strong>Gap in Coverage</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>47.5% between $2,970 and $6,954.52 in drug expense</td>
</tr>
<tr>
<td><strong>Catastrophic Coverage</strong></td>
<td>No cost sharing</td>
<td>No cost sharing</td>
<td>$2.65 generic&lt;br&gt;$6.60 brand copay above limit</td>
<td>5% after $4,750 in OOP</td>
</tr>
</tbody>
</table>

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Conclusion

• Coding, coverage and payment vary by payor, plan type, and site of service

• Specialty drugs that are administered incident to a physician’s service are typically accessed through Medicare Part B and those that are usually self-administered are typically accessed through Medicare Part D

• Medicare Part B cost-share could be covered by supplemental insurance