



CMA Weekly Alert – MARCH 16, 2006

IS IT D OR IS IT B?

INTRODUCTION

According to the Centers for Medicare & Medicaid Services (CMS), some beneficiaries have had problems getting their drugs because prescription drug plans are unsure whether the drugs are covered under Medicare Part D or under Medicare Part B. Medicare Part D will not pay for any medication covered under Parts A or B, as prescribed and dispensed or administered, regardless of whether the beneficiary *has* Part A or Part B. CMS has recently re-issued guidance it developed over the summer to clarify for drug plans, pharmacists, physicians and other providers how to bill for these drugs. CMS has also developed a chart that explains when Part B or Part D will cover a drug.

Part A generally pays for medications related to Part A services: a hospital stay, a Medicare stay in a skilled nursing facility, or drugs used in hospice care for symptom control or pain relief. Part B generally covers medications that cannot be self-administered and that are administered by or under the supervision of a physician in the physician's office. Part B also covers oral anti-cancer drugs, hemophilia clotting factors, drugs furnished by dialysis facilities, drugs furnished as part of an outpatient procedure, and intravenous immune globulin (IVIG) provided in the home. Flu, pneumonia, and Hepatitis B vaccines are billed to Part B.

PROBLEMS FOR NURSING HOME RESIDENTS

Problems have arisen for nursing home residents, in particular, about payment for drugs that must be administered through durable medical equipment (DME). This category includes drugs administered through a nebulizer or an infusion pump. Part B pays for DME; the drugs are covered under Part B as a supply necessary for the DME to perform its function.

Medicare only pays for DME used in the home. Because a nursing home is not considered a beneficiary's home for purposes of the DME benefit, Medicare has never paid for drugs administered through DME for nursing home residents. Before January 1, 2006, Medicaid generally paid for these drugs for residents who were dually eligible for Medicare and Medicaid. Now, however, the drugs administered through DME that are on a Part D plan's formulary should be paid for under Part D for nursing home residents. Beneficiaries who do not live in nursing homes will continue to have drugs administered through DME paid for under Part B. Since Part D will pay for the drugs but not the

DME, Medicare Part B or Medicaid will have to be billed for the DME that administers the Part D drug.

PROBLEMS BASED ON DIAGNOSIS

The issue of whether Part B or Part D pays for a drug may also depend on diagnosis or other factors. For example, Medicare Part B pays for immunosuppressant drugs for beneficiaries whose transplant was covered under Medicare Part A. If the transplant was not covered by Medicare, the drugs should be paid for under Part D.¹ Some drugs that are covered under Part B when used to treat specific conditions such as cancer or anemia may be covered under Part D (i.e., if they are included in a drug plan's formulary) when used to treat other conditions.

WHAT CAN DRUG PLANS, PHYSICIANS, AND BENEFICIARIES DO?

CMS has indicated at informal meetings with physician and beneficiary groups that:

- Drug plans may impose prior authorization requirements, even during the transition period, to determine whether the plan should cover a drug under Part D or whether the drug should be covered under Part B.
- Drug plans may not require beneficiaries to provide a statement from the Part B carrier or Durable Medical Equipment Regional Carrier (DMERC) showing that the drug will not be paid for under Part B.
- Physicians should include the diagnosis on the prescription to help drug plans and pharmacies determine whether Part B or Part D should pay for the drug. Physicians, if they know, are encouraged to include on the prescription whether the drug is paid for under Part B or Part D. CMS, in promoting this solution, did not discuss privacy considerations that might create other barriers to access to drugs if a diagnosis is included on the prescription.

The CMS guidance on whether to bill Medicare Part B or Part D is available at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf.

The CMS Part B vs. Part D coverage table is available at: <http://www.cms.hhs.gov/Pharmacy/Downloads/partsbdcoverageissues.pdf>.

For more information, contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.

¹ Drug plans generally only have to include two drugs in each category or class of drugs. However, CMS has indicated that in 2006, drug plans must include all or substantially all of the drugs that fall within six categories, including immunosuppressants. The five other drug categories for which drug plans must include all or substantially all of the drugs within those categories are anti-cancer drugs, anti-convulsant drugs, antipsychotic drugs, anti-depressant drugs, and anti-retroviral drugs.