Self-Administered Drug Denials Confuse Beneficiaries

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The intersection between Medicare Part B and Part D drug coverage in the outpatient hospital setting is not easy to negotiate. Beneficiaries often assume that Medicare covers medications they receive during an emergency room visit, outpatient procedure, or observation stay under Part B’s payment for those services. They don’t know that, with some exceptions, Part B does not pay for drugs that patients usually self-administer. Thus, when unexpected bills for noncovered drugs collide with their expectations, some beneficiaries call their local SMPs to ask if the hospital is in error or breaking Medicare payment rules.

Kentucky SMP Michelle List has been working since 2014 with two such clients. A hospital billed one of them nearly $430 for four medications – numbing eye drops, an antibiotic ointment, a saline irrigation solution, and an antacid tablet – that she received during outpatient surgery to restore her eyelid’s blinking function. A hospital billed the other client – a dual-eligible beneficiary with full Medicaid and Low Income Subsidy (LIS, or Extra Help) benefits – $94 for a noncovered inhaler. The facility later reduced the beneficiary’s liability to $30, an amount she could not afford to pay.

Both beneficiaries had Medicare Part D drug plans. As is typical, the hospital pharmacies did not belong to the Part D plans’ provider networks and had no obligation to submit claims following the Part B denials for the medications. The responsibility for submitting claims for out-of-network services fell to the beneficiaries, a fact that both overlooked because beneficiaries with Original Medicare rarely submit claims. The Centers for Medicare & Medicaid Services (CMS) generally requires providers to submit claims on beneficiaries’ behalf. Moreover, their Part B Medicare Summary Notices (MSNs) gave no hint of possible Part D coverage in the cryptic note that explained the denials. It said, “Medicare does not pay for this item or service.”

The beneficiary who had eyelid surgery decided in frustration to pay the bill after she protested unsuccessfully the $344 cost for a tube of Ciproflaxin antibiotic ointment that her doctor instructed her to take home for post-operative use. In the case of the dual eligible, the hospital turned the claim over to a collection agency. When she called her local Medicaid office for help, a worker told her that the hospital is at fault because they are supposed to submit claims to Medicaid when Medicare doesn’t pay. Michelle recalled that the beneficiary felt the unfairness of it when she insisted, “I’m being charged and I shouldn’t be.”

With an unfamiliar and seldom-used claims filing procedure, misinformation, conflicting information, reliance on terms like “integral” and “usually” that are open to interpretation, and the lack of meaningful notice at the point of service, it is perhaps no surprise that confusion, frustration, and perplexed questions result.
What are Medicare’s coverage rules for drugs and biologicals provided in the outpatient hospital setting, and when should Part B pay?

Medicare Part B’s coverage for drugs and biologicals is limited. It covers some vaccinations; infused and oral chemotherapy and anti-nausea drugs for cancer patients; immunosuppressive drugs following organ transplants; anti-anemia drugs for certain conditions; antigens to treat allergies; hemophilia clotting factors; drugs and supplies used with covered durable medical equipment (DME); and drugs that are “furnished incident to a physician’s service provided that the drugs are not usually self-administered by the patients who take them.” Medicare also pays for drugs that patients usually self-administer when they function in the outpatient setting as supplies “provided as an integral component of the procedure or are directly related to it.”

This means that in some situations Part B covers drugs that are usually self-administered through a so-called bundled payment for an entire outpatient procedure. It also means that Part B pays hospitals on an itemized basis for more costly drugs that are usually self-administered as long as they are essential to the outpatient procedure. But who decides which drugs are integral to an outpatient procedure and which ones aren’t? To a large extent hospitals do and, as far as beneficiaries are concerned, the line between integral and not integral is not always clear.

CMS coverage rules do, however, clarify one thing: If a hospital pharmacy provides a medication intended for a patient’s post-procedure use at home, Medicare Part B won’t pay because it is deemed a noncovered item under the self-administered drug exclusion. Because the resultant denials are based on a statutory coverage exclusion, hospitals need not issue Advance Beneficiary Notices (ABN) to alert their patients to the likelihood that Medicare Part B won’t pay. CMS rules only require providers to issue ABNs when the medical necessity of an otherwise-covered service or item is in question. Since Part B doesn’t cover drugs that patients usually self-administer (with some exceptions), the ABN rules don’t apply.

With this in mind, which drugs does Part B normally cover as “incident to a physician’s service” and which ones does it deny under the “usually self-administered drug” exclusion? The Medicare Benefits Policy Manual states that injectable drugs, including intravenous drugs, are typically eligible for coverage under the “incident to” benefit. The most common exception is for self-administered insulin. The self-administered drug exclusion applies to topical medications such as ointments and eye drops, oral medications, and suppositories as long as they are not integral to an outpatient procedure. CMS guidance further defines “usually” to mean that Medicare excludes Part B coverage for a drug if more than 50 percent of beneficiaries self-administer it.

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There are at least four things to do.

1. Educate beneficiaries about the explanatory notes on the MSN. Beneficiaries need to know that a note that says, “Medicare does not cover this item” to explain a self-administered drug denial refers only to Medicare Part B. It has no bearing on the beneficiary’s Part D coverage that, by design, covers self-administered prescription drugs, including ointments and topical medications.
Educate beneficiaries about the price difference between hospital pharmacies and retail pharmacies. The difference in cost between a hospital pharmacy and an in-network retail pharmacy for the same drug can be huge. The antibiotic ointment that costs $344 at the hospital pharmacy might cost $100 less at a network pharmacy. The Kentucky beneficiary said that she would have asked her doctor to write a prescription to take to her neighborhood druggist had she known that the hospital would charge so much more for the ointment.

Beneficiaries also need to know that hospitals can bill them for the difference between the Part D plan’s payment and the hospital’s list price for a self-administered drug. Hospitals, however, are not obliged to try to collect this differential. The HHS Officer of Inspector General (OIG) announced in October 2015 that hospitals under certain conditions can waive or discount these charges without violating the law that prohibits inducements to beneficiaries. Any beneficiary can receive a waiver. They should ask about it if it’s not offered.

Encourage beneficiaries to submit claims to their drug plans when Medicare Part B denies coverage for outpatient drugs. As she dealt with coverage denials that dated to 2012, Michelle List learned that her clients’ Part D plans – Express Scripts and First Health – allowed three years from the date of service for filing claims. After submitting copies of the billing statements and Part B MSNs, both plans covered the self-administered drugs. The beneficiaries received checks in the mail that surprised and delighted them.

Educate providers about billing protections for low-income Medicare beneficiaries. Beneficiaries who qualify for full Medicaid benefits with coverage for Medicare cost-sharing charges through the Qualified Medicare Beneficiary (QMB) program are, by definition, poor. The law prohibits balance billing for the Part A and Part B deductible and coinsurance charges. Many providers don’t know about the prohibition and those who do may realize that it’s not absolute. That’s because the prohibition applies to Medicare-covered services and not to services and items that the law excludes from Medicare coverage.

Does this mean that a hospital can bill a dual-eligible beneficiary for self-administered drugs provided in an outpatient setting when Medicare denies payment? Not necessarily. In such cases, it may help to remind hospital billing staff that beneficiaries with full Medicaid and LIS benefits should pay no more than $3.60 out of pocket for a brand name drug and even less for generics. Pharmacies that try to collect more from LIS beneficiaries may be subject to sanction. Finally, it might also help to note that Medicare covers the price differential between Part D plan payment rates and the hospital pharmacy’s higher costs for those with LIS. It gets at the point that providers who help their dual-eligible Medicare patients file out-of-network Part D claims benefit, too.

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