American Society of Interventional Pain Physicians®

Fact Sheet On Inappropriate Reimbursement Patterns of Medicare Advantage Plans

The American Society of Interventional Pain Physicians (ASIPP) is a not-for-profit professional organization founded in 1998 which now comprises over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States. ASIPP also has affiliated state societies in all 50 states and Puerto Rico.

In addition to the many factors helping to accelerate the extinction of independent practitioners, there are multiple issues related to rapidly growing Medicare Advantage Plans' escalating policies causing denial of access and inappropriate reimbursement practices.

Medicare Advantage or Disadvantage

Since the 1970s, Medicare beneficiaries have had the option to receive Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the federally administered traditional Medicare program. The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program "Medicare+Choice." It was later renamed "Medicare Advantage" through the Medicare Modernization Act (MMA) of 2003. Medicare payments to plans for Medicare Part A and Part B services are projected to total $172 billion in 2015, accounting for 27% of total Medicare spending (CBO April 2015 Medicare Baseline).

In 2015, the majority of the 55 million people on Medicare are covered by traditional Medicare, with 31% enrolled in a Medicare Advantage plan **(Fig. 1)**. Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million to 16.8 million in 2015.

Medicare contracts with insurers to offer different types of health plans **(Fig. 2)**.

Since 2006, Medicare has paid plans under a bidding process. The ACA of 2010 revised the methodology for paying plans and reduced the benchmarks. For 2011, benchmarks were frozen at 2010 levels. Reductions in benchmarks are being phased-in from 2012 through 2016. By 2017, when the new benchmarks are fully phased-in, they will range from 95% to 115% of traditional Medicare costs

Medicare Advantage Benefit Package

Medicare Advantage plans are required to offer a benefit "package" that is at least equal to Medicare's and cover everything Medicare covers, but they do not have to cover every benefit in the same way.

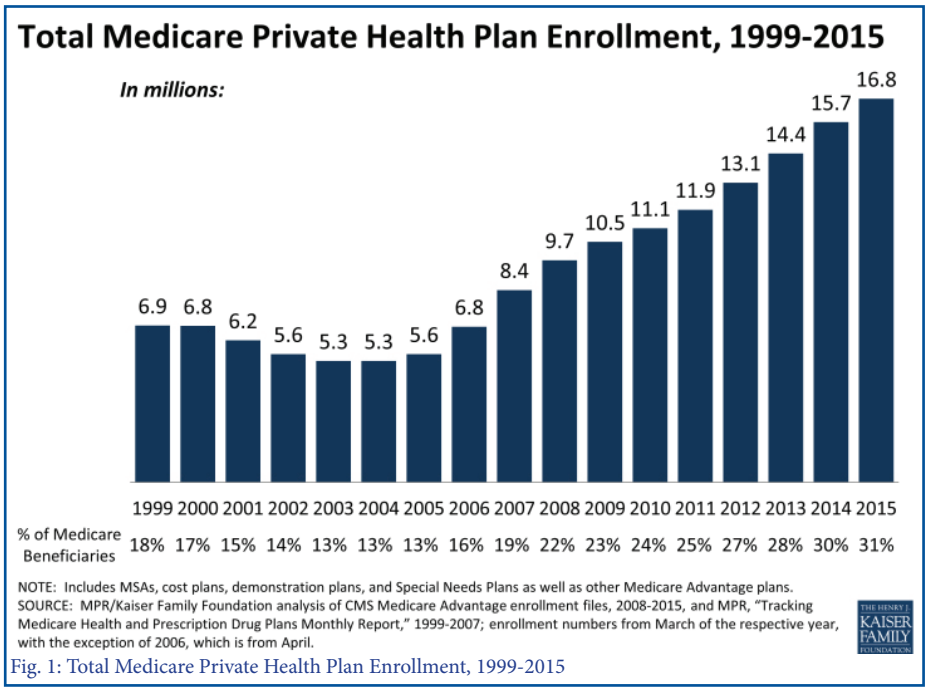

Fig. 1: Total Medicare Private Health Plan Enrollment, 1999-2015

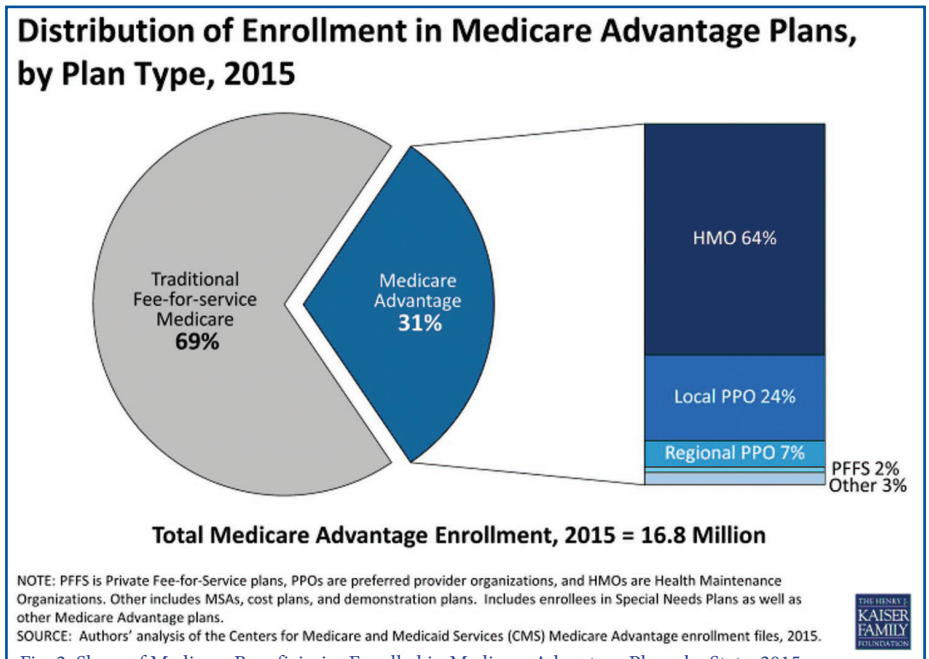

Fig. 2: Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015

All Medicare Advantage plans are required to limit out-of-pocket costs for Parts A and B to no more than $6,700 per year.

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Present Issues for IPM: Denial of Access

Medicare Advantage is denying multiple procedures with unreasonable explanations.

One common procedure denied is percutaneous adhesiolysis, CPT 62264, despite the fact that it is covered by Medicare in all states.

Quoted Reasons for Denying Access and Inappropriate Reimbursement

Medicare Advantage Plans, in a dictatorial fashion, claim these treatments are:

- Experimental and investigational
- They do not have LCDs
- Deny all appeals and ask to follow the Web site
- Refuse to follow the terms of the contracts and push physicians out of network

This procedure is performed in patients who are refractory to conservative management, epidural injections, and drug therapy after surgical interventions, and who suffer with symptomatic spinal stenosis. There is substantial literature showing the efficacy of this procedure which has been demonstrated in high-quality, randomized controlled trials and systematic reviews, yet the "experts" at Medicare Advantage Plans say that it is experimental and investigational.

- It has become very common for Medicare Advantage to provide misinformation.
- Medicare Advantage Plans are denying numerous procedures and services which are covered by traditional Medicare Part B.
- Medicare Advantage Plans are changing reimbursement policies without following traditional Medicare policies, thus reducing payments in some cases by 50%.
- Medicare Advantage Plans are not following the terms of the contracts and forcing physicians to be out of network so that they can pay whatever they want to without following traditional Medicare policies.
- Medicare Advantage Plans are denying access by ignoring contractual obligations.

Medicare Advantage Plans: Integrity Manual

The basic rule as shown in Chapter 4 of the Medicare Managed Care Manual describing benefits and beneficiary protections, Section 10 (Introduction) and Section 10.2 (Basic Rule) shows:

A Medicare Advantage Organization (MAO) offering an MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered "Part B only" enrollee. **The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying on behalf of enrollees for the benefits.**

Administration of the Medicare program is governed by Title XVIII of the Social Security Act (the Act). Under the Medicare program, the scope of benefits available to eligible beneficiaries is prescribed by law and divided into several main parts. Part A is the hospital insurance program and Part B is the voluntary supplementary medical insurance program.

Obviously this includes all services provided by Medicare. Medicare coverage and payment is contingent upon a determination that services are in a covered beneficiary category.

In general, Medicare coverage and payment are contingent upon a determination that:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body member, or is a covered preventive service.

Further, this section also defines the benefits and access to be available to all beneficiaries for all covered Part A and Part B services.

Section 10.2.2 provides an exception to requirements for MA plans in order to cover fee-for-service benefits; however, none of these include not providing these services for the procedures in question.

Failure to provide these services may be considered as discrimination under Section 10.5.2 (Anti-Discrimination) based on race, color, national origin, medical history, claims experience, and disabilities. The Centers for Medicare and Medicaid Services (CMS) is also obligated to review for discrimination and steering. Thus, the procedure is covered.

Experimental and Investigational

The procedure is not experimental and investigational. It is medically necessary. There is ample evidence to show the efficacy of this procedure. Further, all Medicare fee-for-services reimburse for this procedure across the nation. Consequently, Medicare Advantage Plans cannot apply the clause.

Lack of Local Medicare Coverage Policies

Local coverage determination (LCD) policies are policies used to make coverage and coding decisions in the absence of specific statutes, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

LCD policy is an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment. In addition, LCDs outline how contractors will review claims to ensure that they meet Medicare coverage requirements.

Identification of a need for an LCD is based on a validated widespread problem identified for potentially high-dollar or high-volume services, to assure beneficiary access to care, or when frequent denials are issued or anticipated.

Thus, LCDs are not essential for each and every procedure. Consequently, there are no LCDs in any state in the United States or Puerto Rico for this procedure. All Medicare fee-for-service programs reimburse this procedure without an LCD, despite a multitude of requests from the providers to issue one. The refusal by Medicare carriers is based on the fact that it does not meet the criteria for an LCD with any widespread problem, high-dollar amount, or billing issues.

Instead of covering the procedure, Medicare Advantage Plans, along with other carriers, have issued a national coverage determination or a noncoverage policy (NCD). NCDs are issued by CMS which are applied across the country. CMS has never considered this procedure for NCD; however, Medicare Advantage Plans are unlawfully, unilaterally issuing NCDs.

The multiple issues are related to the advantage plans denying access and care by refusing to follow:

- Traditional Medicare coverage policies
- Their own contractual terms
- Traditional Medicare billing and coding practices with elimination of modifiers and reduction in reimbursement rates much below traditional Medicare bringing the rates down in some cases to 50% of traditional Medicare
- These actions push physicians into nonparticipating status with a lack of access to patients or major out-of-pocket expenses.

Out-of-pocket expenses are enormous for services like interventional pain management since most of the time they are below $300 and copays of office follow-up visits exceed physician-approved charges for these procedures.

Future Actions

Achieving a reasonable balance among multiple goals for the Medicare program—including keeping Medicare fiscally strong, setting adequate payments to private plans, and meeting beneficiaries' health care needs—will continue to be a critical issue for policy makers in the future.

It is essential that CMS reverse the decisions and insurers be provided with appropriate instructions and remediation measures to providers.

If you have any questions, please feel free to contact us one of us: Laxmaiah Manchikanti, MD, at drm@asipp.org; Peter Staats, MD, at peterstaats@hotmail.com; Tim Hutchinson at hutchinsont@gtlaw.com; Monica Prahl Schulteis at schulteism@gtlaw.com; Jeff Mortier at jmortier@rmvbllp.com; or Jeff MacKinnon at jmackinnon@rmvbllp.com.