



CALCULATION OF PRESCRIPTION DRUG COSTS IN MSA ALLOCATIONS

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On December 30, 2005, the Centers for Medicare and Medicaid Services (CMS) issued a Memorandum addressing the impact of Part D prescription drug coverage on workers' compensation settlements.

According to the CMS Memorandum, all workers' compensation settlements "that occur

on or after January 1, 2006, must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare."

Beginning on January 1, 2006, CMS now requires a cover letter identifying, "separate amounts for:

(1) future medical treatment, and (2) future prescription drug treatment." Additionally, the submission must include an explanation as to how the submitter calculated the future prescription drug treatment amount.

According to CMS, "If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare's interests." Failure to adequately consider Medicare's interests may result in significant exposure to the parties involved in the settlement.

This directive will dramatically impact workers' compensation settlements nationwide. Medicare Set-Aside (MSA) allocations will increase considerably because prescription drugs can be one of the largest cost categories of future medical care. As a result, it is critical that every effort be made to appropriately contain the cost of future prescription drugs while still "reasonably considering" Medicare's interests.

At this time, Medicare has not established specific guidelines for the calculation of future prescription drug costs in MSA allocations. Furthermore, the Workers' Compensation Review Center-Joint Venture (WCRC-JV) will not be "independently pricing" the cost of future prescription drugs until on or after January 1, 2007. It is incumbent upon the industry to calculate these costs and it is anticipated that CMS will then

compile statistics on the various methods used this year to develop policy for the future.

The CMS Memorandum provides that the submission, "... must include an explanation as to how the submitter calculated the future prescription drug treatment amount (*i.e.*, actual costs, average wholesale price, etc.)." It is imperative that a method is used to calculate the future prescription drug treatment amount that: (1) can be justified, and (2) is the most cost effective method available. Some calculation methods to consider are the following:

(1) Average Wholesale Price (AWP)

The AWP was intended to represent the average price at which wholesalers sell drugs to physicians, pharmacies, and other customers. According to the *Red Book*, the pricing information is "based on data obtained from manufacturers, distributors, and other suppliers."¹ The available commercial publications of AWP include *First Databank*, *Medi-span*, and *Red Book*. Because of differences in methodology, a specific drug's AWP published by each of these sources may vary. Although there has been concern regarding the accuracy of the AWP, most State Medicaid programs and private health insurers base their reimbursement formulas on a fixed discount from AWP, largely



because no alternative, more accurate, data source for drug pricing is currently available.

(2) Workers' Compensation Reimbursement Rate

This rate is the rate determined by statute in the state of jurisdiction. Typically, the workers' compensation reimbursement rate is higher than the AWP with some exceptions such as California where the WC reimbursement rate is lower than the AWP.

(3) Actual Billed Amount

This is the amount actually billed to, and paid by, the primary payer. This amount can be determined by reviewing the primary payer's medication claim payment ledger. The use of this methodology would enable payers who have negotiated discounted network rates below the workers' compensation reimbursement rate and AWP to utilize these rates in calculation of the future prescription drug component of the MSA.

In addition to these methods of calculation, it is incumbent upon anyone submitting a proposal to CMS to consider any other methods to reduce the prescription drug cost.

(A) Rated Age

Utilization of a rated age to reduce the life expectancy of a claimant is critical to limit the period of cost projection.

(B) Substitution of Less Expensive Generic Equivalent

Brand-name drugs are substantially more expensive than generic equivalents. Consequently, it is advisable to increase the use of generic equivalents and reduce reliance on brand-name drugs whenever possible.

(C) Professional Judgment

Professionals completing MSA allocation projections should use their best judgment to project future prescription drug use. It is a generally accepted practice in the field of future medical cost evaluation that if a definitive medical procedure, surgery, or treatment program is projected for the future, the professional will make the assumption that the procedure, surgery or program will be successful and adjust future medications accordingly.

(D) Intervention with Prescribing Physician

When the anticipated future use of prescribed drugs is not apparent based upon review of the medical records, it may be appropriate to obtain this information in writing

from the prescribing physician so that drugs are not projected over the entire life expectancy inappropriately.

(E) Pharmacy Utilization Review

If a particular case appears to fall outside standard practice guidelines without documented justification, an independent pharmacy utilization review by a licensed pharmacist may be of benefit. This may provide the necessary documentation to support the allocation professional's projection.

(F) Exclusion of Drugs not Otherwise Covered by Medicare

The MSA allocation cost projection should only include future medical expenses that would otherwise be covered by Medicare. Since the addition of Part D covered services, allocation professionals will undergo a learning curve regarding which drugs are covered and which are not. This is further complicated by the fact that there are differences between what drugs will be covered among the various Part D prescription drug plans (PDP's). Note that the following drugs are excluded from Part D plans:

1. Drugs used for anorexia, weight loss, or weight gain
2. Drugs used to promote fertility
3. Drugs used for cosmetic purposes or hair growth
4. Drugs used for the symptomatic relief of cough and colds
5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
6. Non-prescription drugs

7. Inpatient drugs
8. Barbiturates
9. Benzodiazepines

There is no guarantee as to whether CMS will take issue with any of the outlined approaches and they can certainly issue policy statements at any time. However, given the absence of specific CMS guidelines, the use of these mechanisms appears to be a reasonable consideration of Medicare's interest.

¹ Medical Economics Staff, *Red Book*, 106th Ed. (Montvale, N.J.: Thomson Medical Economics, 2002), 169.

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