Movement Disorders
CLINICAL PRACTICE

Reply to: DUOPA® is an Excellent Alternative Treatment but with Some Caveats

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A full issue of the Journal of the American Medical Association was recently devoted to the important topic of industry influence on biomedical publishing.[1] Financial relationships are sources of bias that warrant special attention, and we adhered closely to MDCP's disclosure policies to ensure transparency in this regard.[2] Dr. Lamichhane's letter[3] highlights the success of these efforts.

Authors with consulting income from Abbvie are among those who gained early experience with carbidopa/levodopa enteral suspension (CLES) in the US through involvement in the clinical trials that led to FDA approval. A central intention of the authors was to share insights from first-hand experience that cannot be readily gleaned from clinical trial data and the FDA-approved marketing information derived from these trials. Sponsored writing and editorial assistance was a catalyst that mitigated time and energy constraints faced by academic clinicians, but in the absence of such support, the content would have been identical. The first author, who has no financial relationship with Abbvie, vetted the utility and truthfulness of every word in the document, and the peer review process validated the content.

Implementation of any intervention in clinical practice includes reimbursement considerations, and we agree that these realities can create barriers to access for patients who otherwise could benefit from CLES. Solutions to these challenges are highly specific to local factors that influence the allocation of resources in each practice environment. Many elements of good clinical care are not directly reimbursed, and every practice makes choices about whether and how this unreimbursed care is provided. Advocacy by clinicians and professional associations, patients and support organizations, and industry are important forces for influencing reimbursement policies.

With respect to specific reimbursement challenges: (1) although there is no CPT code for drug titration, there is significant counseling and education that occurs concurrently with drug titration that could support time-based billing; (2) in Medicare Part A inpatient environments, medications are not reimbursed separately from other care costs, but rather must be covered by the fixed daily rate for the diagnosis-related group (DRG). When drug costs exceed the DRG reimbursement, as is currently the case for CLES, justification of this expenditure must be made on a case-by-case basis. We highlight impending skilled nursing facility placement as a relative contraindication to initiation of CLES for precisely this reason. For a brief inpatient stay, facility policies often permit patients to use their home supply of non-formulary drugs, with institutional pharmacy oversight. For longer inpatient hospital or rehabilitation admissions, a provider may need to communicate with the facility director to highlight the clinical impact of CLES relative to oral therapy (e.g., improved motor function can translate to earlier discharge).

The impact of a publication is ultimately the result of collaboration between authors, editors, reviewers, and readers. The presence of financial conflicts of interest from industry support should not derail endeavors that can ultimately benefit patients; transparency is what ensures the integrity of the content. We are grateful to all parties involved in the scrutiny of this work.

Author Roles

1. Research Project: A. Conception, B. Organization, C. Execution; 2. Statistical Analysis: A. Design, B. Execution, C. Review and Critique; 3. Manuscript Preparation: A. Writing the First Draft, B. Review and Critique.

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Disclosures

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