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2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Introduction to NCDs and LCDs

5/11/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- Basis for Medicare coverage
- NCD development
- NCD organization and enforcement
- LCD development
- LCD organization and enforcement
- Claim denials
- Resources

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Objectives

- Gain a better understanding of NCDs and LCDs
- Utilize NCDs and LCDs to ensure compliance with documentation and billing requirements
- Understand
  - NCD and LCD development processes
  - How you can contribute to the LCD development process
  - Reconsideration process for LCDs
  - Process to complete an adjustment to certain partially denied claims

Today's Presenters

- Provider Outreach and Education Consultants
  - Jean Roberts, RN, BSN, CPC
  - Andrea Freibauer
  - Kathy Windler

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Basis for Medicare Coverage

Basis for Covered Medicare Services

- Title XVIII of Social Security Act per Section 1862(a)(1)(A) excludes services not “reasonable and necessary” unless otherwise specifically noted
  - Coverage for services under Medicare based on medical necessity and within scope of Medicare benefit category

Role of CMS and MACs in Determining Covered Services

- Centers for Medicare & Medicaid Services Internet-Only Manuals
  - CMS IOM, Publication 100-02, *Medicare Benefit Policy Manual*
    - Details on scope of covered Part A and Part B services
  - CMS IOM, Publication 100-03, *Medicare National Coverage Determination (NCD) Manual*
    - Sets policy for determining medical necessity for specific services
- When no national coverage policy exits, MACs have discretion to make local coverage decisions

Claim Denials Are a Costly Problem

- Claim denials related to NCDs and LCDs make up large percentage of denied claims
  - Denials represent major expense to providers in terms of time and money
- To fix and prevent denials, providers must know how to access and correctly interpret Medicare NCDs, LCDs and policy articles

NCD Development

MEDICARE NATIONAL COVERAGE PROCESS

The Medicare National Coverage Process is a nine (9) month process. For the initial six (6) months, the following phases often include the following in the order listed:

Preliminary Discussions → Benefit Category → National Coverage Request → Staff Review → External Technology Assessment And / Or Medicare Coverage Advisory Committee → Staff Review → Draft Decision Memorandum Posted

The final three (3) months of the Medicare National Coverage Process include a thirty (30) day Public Comments phase, followed by a sixty (60) day requirement to complete the Final Decision Memorandum and Implementation Instructions phase.

Public Comments → Final Decision Memorandum and Implementation Instructions

Upon completion of the Final Decision Memorandum and Implementation Instructions phase, two (2) further phases are possible: the Final Decision Memorandum and Implementation phase initiates an appeal or the Reconsideration phase will further initiate the Preliminary Discussions phase.

Final Decision Memorandum and Implementation Instructions → Department Appeals Board

Or

Final Decision Memorandum and Implementation Instructions → Reconsideration → Preliminary Discussions

National Coverage Determinations

- Nationwide coverage instructions
  - Binding on all contractors
  - Applies to all Medicare claims
- CMS establishes NCDs
  - CMS develops through evidence-based process, with opportunities for public participation
  - Outside technology assessments and/or consultation with Medicare Evidence Development & Coverage Advisory Committee

Internally Generated NCD Review

- CMS may internally initiate NCD process when
  - Significant questions about health outcomes related to use of item/service
  - New evidence indicating national coverage review warranted
  - NCDs are implemented nationally and do not vary by location
    - Local coverage policies vary in language or implementation
  - Health technology represents clinical advance and likely to result in improvement in beneficiary health outcome

Proposed NCD Decision

- Proposed decision normally issued for public comment within six months of opening NCD review
  - 30 days for public comment
- Not later than 60 days following 30-day comment period, final NCD issued

Have an Idea for an NCD?

- Must submit complete formal request to CMS
- Prior to doing so, communicate with Coverage and Analysis Group within Center for Clinical Standards and Quality
- Many potential requesters withdraw or amend initial requests after informal communication because
  - Existing coverage already available
  - Outside scope of an NCD
  - Falls outside scope of benefits

What Constitutes a Complete, Formal Request for an NCD?

- Following conditions must be met
  - Final letter identified as “A Formal Request for a National Coverage Determination” submitted
  - Submit scientific evidence supporting request for coverage
  - Documentation must include full/complete description of item/service
  - Must include information regarding use of item/service subject to FDA regulation
  - Must state Medicare Part A or Part B benefit category or categories in which item/service falls

Did You Know…

- Requests for NCDs may be submitted
  - Electronically
    - NCDRequest@cms.hhs.gov
  - Hardcopy
    - Centers for Medicare & Medicaid Services
      Director, Coverage and Analysis Group
      7500 Security Blvd.
      Baltimore, MD 21244
  - Additional Information
    - Medicare Coverage Determination Process
    - Federal Register: Medicare Program; Revised Process for Making National Coverage Determinations

External Request for New NCD

- Request to establish, limit or remove coverage may be initiated by
  - Beneficiary
  - Manufacturer
  - Physician
  - Professional association

External Request for New NCD

- Tracking sheet published on CMS MCD contains
  - Reference number
  - Name of issue
  - Requests for public comment
  - Summary of actions taken
    - CMS NCD Coverage Database > Public Comments > select “See National Coverage Analyses (NCAs) Open for Public Comment”

Reconsideration of Existing NCD

- External request
  - Must file complete formal request for reconsideration in writing
- Internally generated request
  - New evidence supporting material change
  - CMS will seek public comments

NCD Organization and Enforcement

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National Coverage Determinations

- NCDs assigned numeric identifier and published on CMS website
  - NCD alphabetical index and index by chapter/section on CMS Medicare Coverage Database
  - CMS Internet-Only Manual Publication 100-03, *National Coverage Determinations Manual*
    - Organized into four "parts" based on NCD numeric identifier
  - New or revised NCDs are "announced" via Change Requests and instructions are manualized in applicable sections of IOMs

National Coverage Determination Examples

- NCD 110.21 “Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions”
- NCD 110.24 “Chimeric Antigen Receptor (CAR) T-cell therapy”
- Lab NCD 190.16 “Partial Thromboplastin Time (PTT)”
- Lab NCD 190.17 “Prothrombin Time (PT)”
- Noncovered
  - NCD 80.7 “Refractive Keratoplasty”
  - NCD 130.8 “Hemodialysis for Treatment of Schizophrenia”

CMS Website

- CMS Website
  - Medicare Coverage – General Information
    - Medicare Coverage Database link
    - ICD-10 link: Transmittal (change request) updates related to NCD
    - Lab NCDs –ICD-10: Files containing lab NCD coding updates
    - Medicare Coverage Determination Process
  - Medicare Coverage Center
    - CMS “home” for coverage information with links to valuable resources
  - Medicare Coverage Database
    - All NCDs & LCDs; proposed NCD decisions; local articles

NCD Automated Edits

- NCDs enforced by automated claims processing system edits
- MACs receive implementation instructions prior to NCD enforcement and notify provider community
- Claims denied when they do not pass system edits for NCDs

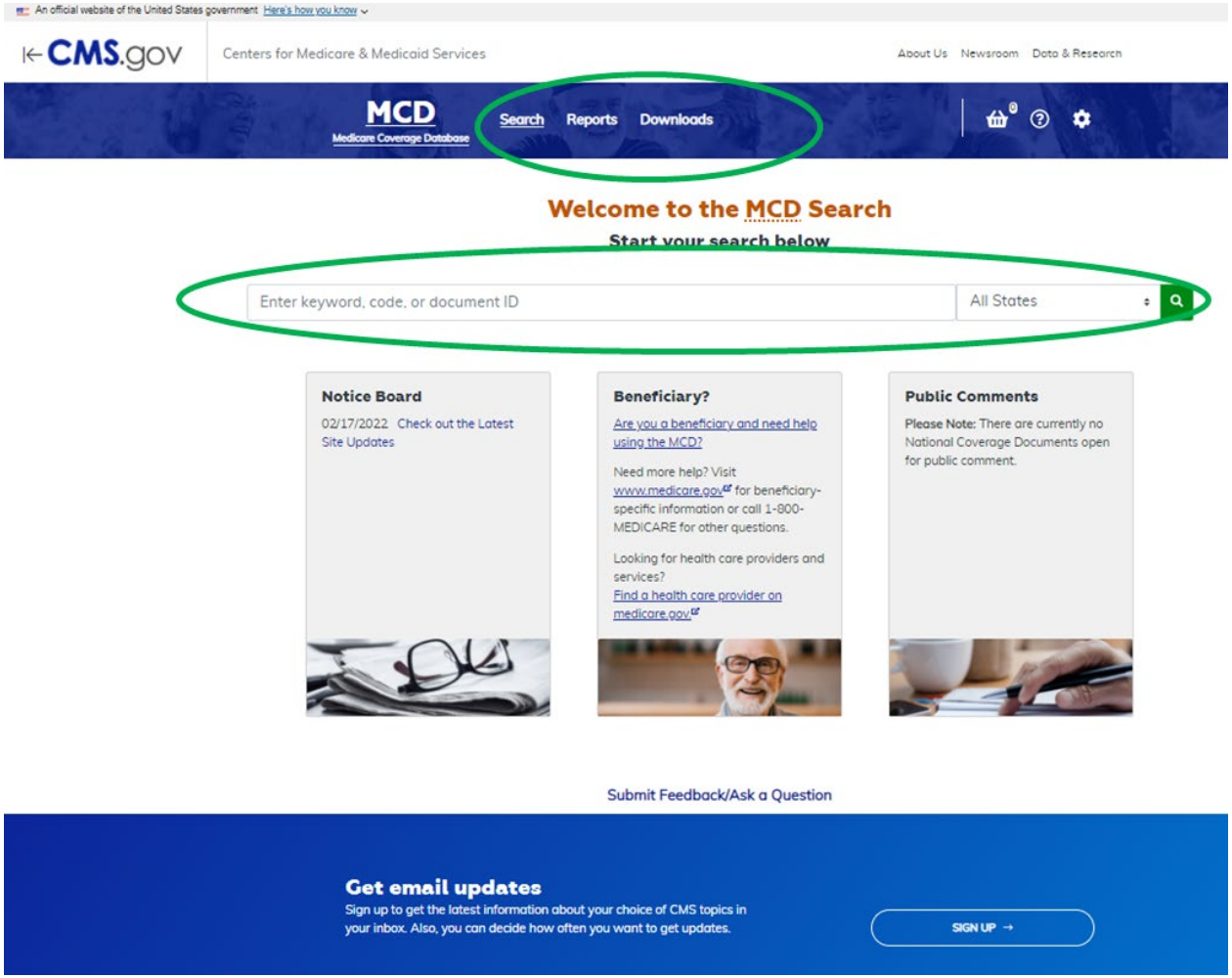
Common NCD Automated Edits

- 52NCD
  - Line level reason code to indicate that the HCPCS on the line and a diagnosis code on the claim matched the NCD edit table list ICD-9-CM deny codes. Service is denied and provider is liable.
- 53NCD
  - Line level reason code to indicate that none of the diagnosis codes on the claim support medical necessity of the services. Modifier “GA” is present on the line or occurrence code 32 is present on the claim and modifier “GA” is not present on any claim line. Service was denied beneficiary liable.
- 54NCD
  - Line level reason code to indicate that none of the diagnosis codes on the claim support the medical necessity of the service. Service is denied and provider is liable.

Medicare Coverage Database

- Located on CMS website
  - Medicare Coverage Database
- Contains
  - All NCDs & LCDs
  - Proposed NCD decisions
  - LCD articles
  - Draft LCDs

Medicare Coverage Database



CMS Website Home > Medicare > Coverage > Medicare Coverage General Information > Search the Medicare Coverage Database

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Local Coverage Determination Coverage Development

Definition

- Definition: Social Security Act section 1869(f)(2)(B)
  - Determination by a MAC
    - Whether or not a particular item or service is covered on a contractor–wide basis in accordance with SSA section 1862(a)(1)(A)
- Identification
  - LCD number: L followed by five digits
  - Billing and Coding Article: A followed by five digits
  - Response to Comments article: A followed by four digits

Benefits of LCDs

- Administrative and educational tools to assist providers to submit correct claims for payment
- Help define Medicare coverage limitations for certain services
- Help reviewers to make consistent, accurate coverage decisions
- NCDs supersede LCDs; however, an LCD may expand/clarify coverage and coding for an NCD

Local Coverage Determinations

- MACs develop LCDs on as needed basis
  - Determines that item or service should not be covered under certain circumstances
  - Discovers problem that demonstrates significant risk to Medicare trust fund
  - Detects overutilization or misuse of items or services
  - By request from external parties (beneficiaries, providers, or manufacturers)

Local Coverage Determinations

- Contractors must ensure all LCDs are
  - Consistent with existing statutes, rulings, regulations, national coverage, payment and coding policies
    - Can supplement existing NCD but cannot supersede
  - Created and approved within established protocols
    - Allows for notification, review and comment by interested parties within specific timeframes
    - Three stages
      - Comment Period, Notice Period, Active Period

Billing & Coding Articles

- Include important coding guidelines and billing instructions not related to medical necessity
  - Each LCD has at least one related article
  - Links are found in Associated Documents section at bottom of an LCD
  - A link to related LCD is also found at end of each article
    - Links are only “live” in active LCDs and articles

LCD Process

- Comment Period (“Draft”) - minimum of 45 days
  - MAC seeks scientific evidence and other scientific-based information related to the proposed LCDs
  - Begins when policy distributed to medical providers and organizations
  - Anyone can comment on LCD
  - May be presented to Contractor Advisory Committee

Draft LCDs and Open Meetings

- Current draft/proposed LCDs found on CMS Medicare Coverage Database
  - MCD Reports > narrow search to NGS and "Proposed Policies"
    - Identify draft LCDs by ID beginning with D followed by five digits
      - Draft identifies whether open or closed for comments
  - Watch for NGS email update with Open Meeting Announcement and link to draft LCDs
- Providers can participate in evaluation of draft/proposed LCDs in their contract type/region

Commenting on Draft LCDs

- View drafts on Medicare Coverage Database
- Comments only considered when submitted during formal comment period
- Draft LCD comments
  - Should submit using address listed at the end of Proposed/Draft Process Information section of draft LCD
    - Typically, comments are sent to
      - National Government Services Medical Policy Unit
        P.O. Box 7108
        Indianapolis, IN 46207-7108
      - Or via email: PartBLCDComments@wellpoint.com

LCD Process

- Notice Period (“Future”) - 45 days
  - LCD finalized after review of documentation and comments
  - Not yet effective but posted to MCD so providers can prepare systems to implement
- Active Period – at end of Notice Period
  - Effective date noted in body of LCD
  - System edits activated for services indicated within LCD on/after effective period date

Did You Know…

- If no written guidelines on coverage of particular non excluded service exist, providers can request creation of new LCD to clarify coverage policy
  - Decision to create new LCD will ultimately be at our discretion
- LCD Request Process
  - New Local Coverage Determination (LCD) Request Process (A56198)

LCD Organization and Enforcement

What Information Can Be Found in LCDs?

- LCDs cover only “reasonable and medically necessary” services
  - Provide coverage indications, limitations and/or medical necessity information for reasonable and necessary tests, items and services
  - Documentation requirements
- Billing and Coding Articles
  - Provide coding guidelines, billing instructions as well as other instructions

LCD Components

- Consistent format, sections include
  - Contractor information
  - CMS National Coverage Policy
  - CMS Publications
  - Coverage guidance
  - Summary of Evidence and Analysis of Evidence
  - General information
  - Revision history
  - Associated documents

Validate Correct Version

- Draft LCD number: DL followed by five digits
- Final LCD number: L followed by five digits
- Validate LCD status
  - Draft, Future, Superseded, Retired
  - Check effective date
    - LCD is in notice period – future date
  - Check revision history

LCD Automated Edits

- LCDs supported and enforced by automated system edits
  - 55A00, 55A01 – This claim was denied by an automated system for not having a covered diagnosis in accordance to the LCD/NCD. Provider may correct diagnosis by submitting adjustment according to instructions for making corrections for automated LCD/NCD denials, or by submitting a written request.

Retired LCDs

- Retired LCD
  - Not replaced by another local policy
  - Policy and any related editing no longer applies after retirement date
- Coverage guidelines
  - Based on national guidelines that exist for coverage and medical necessity determinations

What If There Is No LCD or NCD?

- No active LCD, LCD article, or NCD
  - Check for coverage guidelines in CMS IOMs, CRs, MLN Matters® articles
  - Check NGS Website
  - Check for related medical policy article
  - Make sure service not statutorily or administratively excluded
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16, “General Exclusions From Coverage”
    - LCD L32456 “Noncovered Services”

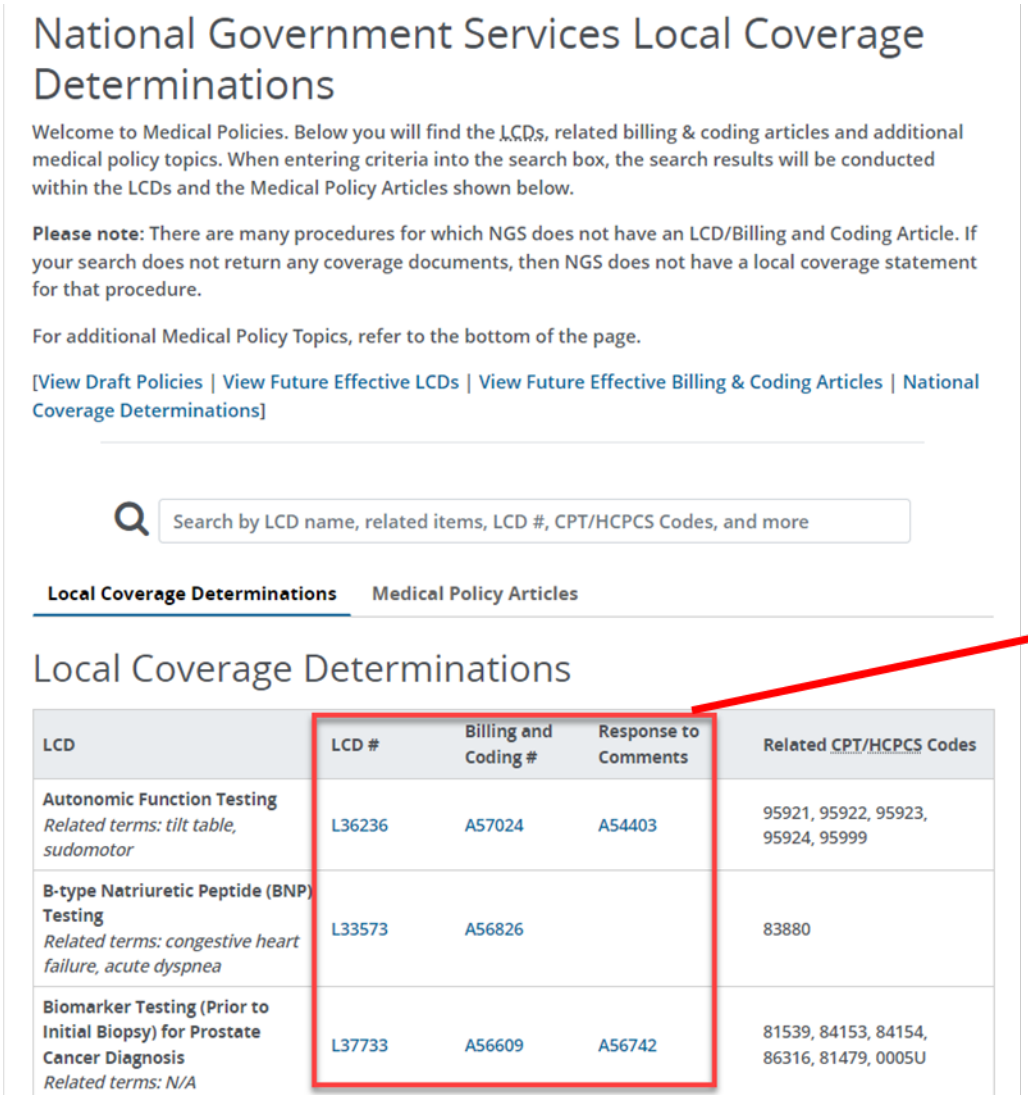
LCD Reconsideration Process

- Mechanism by which interested parties can request revision to LCD
- Guidelines for LCD reconsideration requests
  - Medical Policy Article A52842
- Questions about ongoing LCD reconsiderations can be sent to
  - NGS.LCD.reconsideration@anthem.com

NGS Medical Policy

- LCDs
- Billing and coding articles
- Medical policy articles
- Coverage related information
  - Draft LCDs
  - LCD reconsideration process
  - Medical policy contact information
- Direct link to Medicare Coverage Database

NGS Website > Resources



National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below.

Please note: There are many procedures for which NGS does not have an LCD/Billing and Coding Article. If your search does not return any coverage documents, then NGS does not have a local coverage statement for that procedure.

For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

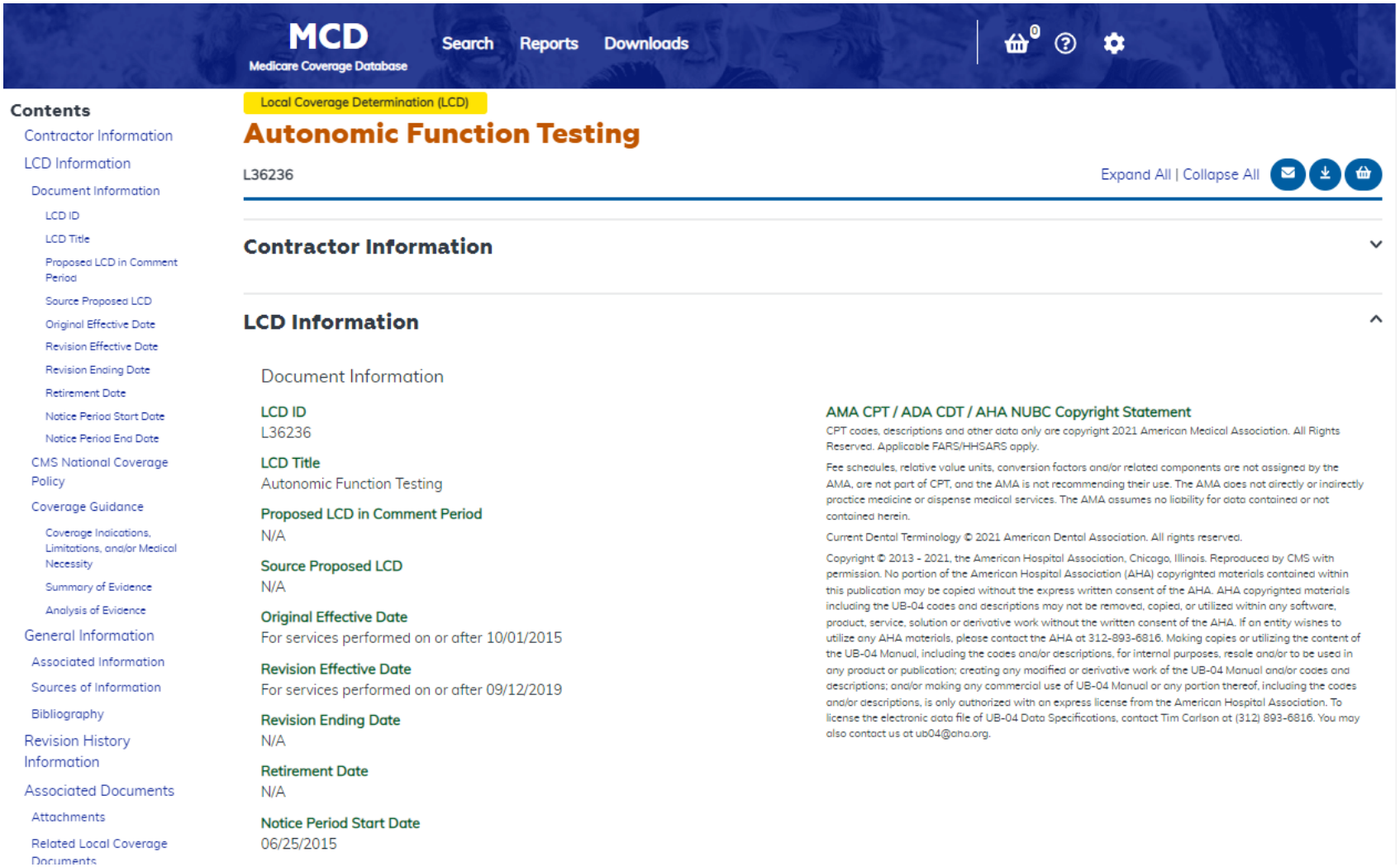
Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95999
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880
Biomarker Testing (Prior to Initial Biopsy) for Prostate Cancer Diagnosis *Related terms: N/A*	L37733	A56609	A56742	81539, 84153, 84154, 86316, 81479, 0005U

Hyperlink(s) to specific document(s) in CMS database

CMS MCD Example: NCD LCD L36236



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Claim Denials

Importance of Documentation

- Medical necessity = underlying basis for Medicare coverage
- Providers must maintain complete medical records documenting services rendered and reasonable and necessary
  - Documentation is deciding factor in determining medical necessity of service in absence of any written statutory or administrative guidance
- Vital: Medical Review Contractors and Appeals

Adjustment Process for NCD or LCD Partially Denied Claims

- Certain partially denied claims can be adjusted
- No need to appeal
- Initiate adjustment for claims partially denied by automated edits for NCDs and LCDs
  - Applies to claims with line item denial reason code of 55A00, 55A01, 52NCD, 53NCD, 54NCD and the 59xxx series
  - Does not apply to claims that received an ADR or postpayment denials
  - Do not use to add charges or change HCPCS/CPT codes

Adjustment Process for NCD or LCD Partially Denied Claims

- Correction Steps (electronic and DDE)
  - Ensuring diagnosis code appropriate for beneficiary and supported in medical records
  - Make appropriate corrections to diagnosis code(s)
    - Delete and rekey denied line(s) to reflect covered charges and units
    - Add condition code “D9” and add remarks
    - Add adjustment reason code “LN”
- NGS article: Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials

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Resources

CMS Resources

- Federal Register / Vol. 78, No. 152 / Wednesday, August 7, 2013 / Notices
  - Medicare Program; Revised Process for Making National Coverage Determinations
- MLN Matters® *MM10901 Revised: Local Coverage Determinations (LCDs)*

CMS Resources

- CMS Internet-Only Manual (IOM) Publication
  - 100-02 "*Medicare Benefit Policy Manual*"
  - 100-03 "*Medicare National Coverage Determinations (NCD) Manual*"
  - 100-04 "*Medicare Claims Processing Manual*"
  - 100-08 "*Medicare Program Integrity Manual*", Chapter 13 - Local Coverage Determinations

CMS Resources: NCD ICD-10 Updates

- ICD-10 and other coding updates specific to NCDs - included in quarterly releases as needed
  - No policy-related changes are included with these updates
  - Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process
- ICD-10 Updates to NCDs
  - NCDs other than Lab
  - Lab NCDs

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NGS Resources: NGS Medical Policy

- NGS LCDs and Additional Information
- Contractor Advisory Committee (CAC)
- Investigational Device Exemption Requests
- Local Coverage Determination Open Meeting
- Local Coverage Determination (LCD) Reconsideration Process - Medical Policy Article A52842

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NGS Resources: NGS Medical Policy

- Medical Policy Contact Information
- New Local Coverage Determination (LCD) Request Process A56198
- Self-Administered Drug Exclusion List: Medical Policy Article A53021
- NGS article on claim adjustments: Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials
- NGS Part A Appeals

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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