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NGS Medicare Virtual Conference

Fall 2021

Introduction to NCDs and LCDs: Learn What They Are and How to Find Them

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
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Objectives

- After today's session, attendees will be able to
  - Discuss what are NCDs and LCDs
  - Utilize NCDs and LCDs to ensure compliance with documentation and billing requirements
  - Request creation of new NCD
  - Submit comments on draft LCDs
  - Understand reconsideration process for LCDs

Agenda

- Basis for Medicare Coverage
- NCD Development
- NCD Organization and Enforcement
- LCD Development
- LCD Organization and Enforcement
- Resources and References

Basis for Medicare Coverage

Basis for Covered Medicare Services

- Title XVIII of Social Security Act Section1862(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

- CMS IOM Publications
  - 100-02 *Medicare Benefit Policy Manual*
    - Details on scope of covered Part A and Part B Medicare services
  - 100-03 *Medicare National Coverage Determination (NCD) Manual*
    - Sets policy for determining medical necessity for specific services
- Where item or service not mentioned at all in CMS Manuals, MACs make 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

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
  - 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
- No later than 60 days following 30-day comment period, final NCD issued

Have an NCD Idea?

- 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

External Requests for New NCD

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

External Requests for New NCD

- Tracking sheet published on CMS MCD contains
  - Reference number
  - Name of issue
  - Requests for public comment
  - Summary of actions taken
    - CMS Website > Medicare > Coverage > Medicare Coverage-General Information > Search the Medicare Coverage Database > Reports > National Coverage What's New Report > NCAs (National Coverage Analyses)

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

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 IOM Publication 100-03, *National Coverage Determinations Manual*
    - Organized into four “parts” based on NCD numeric identifier

National Coverage Determination Examples

- 40.1 – Diabetes Outpatient Self-Management Training
- 110.7 – Blood Transfusions
- 160.15 – Electrotherapy for Treatment of Facial Nerve Palsy (Bell's Palsy)
- 190.17 – Prothrombin Time (PT)
- 260.6 – Dental Examination Prior to Kidney Transplantation

Medicare Coverage Database

- Located on CMS website
- Contains
  - All NCDs and LCDs
  - Proposed NCD decisions
  - Local articles
- Medicare Coverage Database

Let's Take a Look

- CMS Website
  - Home > Medicare > Coverage > Medicare Coverage – General Information
  - Home > Medicare > Special Topics > Medicare Coverage Center > Medicare Coverage Database

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 was denied.
- 54NCD
  - Line level reason code to indicate that none of the diagnoses on the claim support the medical necessity of the service. Service denied the provider is liable.

Disagree With an NCD Denial?

- First check date(s) of service against NCD revision history
  - Make sure you are using correct NCD version for DOS
- Questions to ask
  - Are a combination of diagnosis codes required?
  - Is a specific place of service required for CPT/HCPCS code in question? (e.g. inpatient only)
  - Is there a frequency limit which caused denial?

Adjusting NCD Partially Denied Claims

- Electronic adjustments allowed for claims partially denied by automated edits for NCDs
- Applies to claims with line item denial reason code of 52NCD, 53NCD or 54NCD
- Make appropriate corrections to DX
  - Use claim change reason code D9
  - Adjustment reason code LN
  - Delete and rekey denied line(s) back to covered

LCD Development

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

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
  - 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

LCD Process

- Comment Period (“Draft”) – minimum of 45 days
  - 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 MCD
  - Reports > Local Coverage Proposed LCD by Contractor Report
- Providers can participate in evaluation of draft/proposed LCDs in their contract type/region

Commenting on Draft LCDs

- View drafts on MCD
- Comments only considered if submitted during formal comment period
- Contact for Comments on Proposed LCD
  - National Government Services Medical Policy Unit
    P.O. Box 7108
    Indianapolis, IN 46207-7108
  - 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
- Process within Local Coverage Article
  - New Local Coverage Determination (LCD) Request Process (A56198)

Billing and 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

Medical Policy Articles

- Medical policy articles separate from SIAs
  - Do not contain words “Supplemental Instructions Article” or “Attached to LCD” in title
  - Clarify points contained in NCDs or CMS manuals
  - May contain either medical necessity or coding instructions
  - Policy articles reviewed annually

LCD Organization and Enforcement

What Information Can Be Found in LCDs?

- LCDs consist of only “reasonable and necessary” information
  - Indications/limitations for reasonable and necessary tests, items and services
  - Documentation requirements
- Coding guidelines or other instructions not related to medical necessity published in related billing and coding articles

LCD Components

- Consistent format, including
  - Title page
  - Coverage guidance
  - General information
    - Documentation requirements, utilization guidelines, appendices, citations
  - Revision history
  - Links to associated Billing and Coding Articles

Make Sure You Are Looking at Correct LCD Version!

- Draft LCDs start with “DL”
- Final LCDs start with “L”
  - Check effective date: if it is in future, LCD is in a notice period!
  - Check revision history
- CMS applies “Draft”, “Future”, “Superseded” or “Retired” watermarks as appropriate

Medical Policy Center

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

Let's Take a Look

- NGS Website
  - Resources > Medical Policies

Medicare Coverage Database

- Located on CMS website
  - Medicare Coverage Database
- Contains
  - All NCDs and LCDs
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Let's Take a Look

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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

- When an LCD “retired” by contractor, policies no longer apply to any claims after retire date
  - Retired LCDs not replaced by any other local policy
- Coverage guidelines revert to whatever national guidelines exist for coverage and medical necessity determinations

What if There is No LCD or NCD?

- Check for coverage guidelines in CMS IOMs
- 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”

Importance of Documentation

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

Disagree With LCD Denial?

- First check date(s) of service against LCD revision history
  - Make sure using correct LCD version for DOS
- Questions to ask
  - Combination of diagnosis codes required?
  - Specific place of service required for CPT/HCPCS code in question (e.g. inpatient only)?
  - Is there a frequency limit which caused denial?

Adjusting LCD Partially Denied Claims

- Electronic adjustments allowed for claims partially denied by automated edits for LCDs
- Applies to claims with line item denial reason code of 55A00 or 55A01
- Make appropriate corrections to DX
  - Use claim change reason code D9
  - Adjustment reason code LN
  - Delete and rekey denied line(s) back to covered

Disagree With LCD Denial?

- If you have verified services meet all conditions for coverage in LCD, contact PCC to request claim be reviewed for possible reprocessing
  - NGS Website > Resources > Contact Us > Provider Contact Center
- Hours of operation
  - Monday through Friday: 8:00 a.m.–4:00 p.m. ET
  - Closed 2nd and 4th Friday of the month for training: 12:00–4:00 p.m. ET

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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

Resources and References

Resources

- CMS Internet-Only Manual Publication
  - 100-02, *Medicare Benefit Policy Manual*
  - 100-03, *Medicare National Coverage Determinations Manual*
  - 100-08, *Medicare Program Integrity Manual,* Chapter 13, Local Coverage Determinations

References

- Federal Register / Vol. 78, No. 152 / Wednesday, August 7, 2013 / Notices
  - Medicare Program; Revised Process for Making National Coverage Determinations

Thank You!

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

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