COLLEGE of AMERICAN PATHOLOGISTS

MEDICARE PAYMENT AND HOW PATHOLOGISTS INFLUENCE LOCAL COVERAGE DETERMINATIONS

INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) give great latitude to local Medicare contractors to establish coverage policy in their geographic jurisdiction. Through local coverage determinations (LCDs), Medicare contractors make most Medicare coverage decisions.

Federal law requires Medicare contractors to seek physician input into their coverage decision process through contractor advisory committees (CACs). Through these committees, physicians can have significant influence over the coverage decision process.

Effective interaction with the Medicare reimbursement system by physicians requires an understanding of the local Medicare reimbursement process. This document focuses on the basics of local Medicare reimbursement, the influence that pathology carrier advisory committee representatives have in shaping the policies, and the support that the College of American Pathologists (CAP) provides for pathology committee representatives.

MEDICARE CONTRACTING REFORM

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) called for Medicare contracting reform and the replacement of all Fiscal Intermediaries (responsible for the administration of Medicare part A claims) and carriers (responsible for the administration of Medicare part B claims) with new contractors, called Medicare Administrative Contractors (MACs), to administer both Medicare Part A and Part B claims.

The CMS used competitive bidding procedures to replace all carriers and Fiscal Intermediaries by 2011, beginning in 2005.[1] This changeover to MACs streamlined Medicare's number of contractors from 48 down to 20. The 20 MACs include:

- 12 to process both Part A and Part B claims (A/B MACs)
- 4 to process durable medical equipment (DME) claims (DME MACs)
- 4 to process Home Health & Hospice claims (HH & H MACs)

The new jurisdictions represent distinct, non-overlapping locations and were created with the goal of balancing the number of fee-for-service beneficiaries and providers as well as the number of claims processed. MACs are selected through a competitive bidding process and are subject to annual contract renewals based on specific performance requirements. To ensure ongoing quality and efficiency, all MACs compete to renew their contracts every five years.[2] However, the Medicare Access and CHIP Reauthorization Act (MACRA) enacted on April 16, 2015, includes language in Section 509 that authorizes Medicare to extend a MAC contract term from five to ten years if a MAC meets or exceeds performance requirements.[3]

MEDICARE CONTRACTORS

The task of administering the payment of claims for services performed for Medicare beneficiaries is performed by Medicare contractors, typically private insurance carriers that contract with CMS to administer Medicare claims processing in specific jurisdictions. Although Medicare contractors are given significant latitude in establishing coverage policy in their regions, they must adhere to guidelines from CMS on how they establish coverage policy and administer claims. Chapter 13 of Medicare's Program Integrity Manual[5] is the means by which CMS defines policy for Medicare coverage.

CONTRACTOR MEDICAL DIRECTORS

Contractor medical directors (CMDs) are the principal individuals who determine local Medicare policy. Each MAC is required by CMS to have a minimum of one individual designated to serve as the CMD. Responsibilities of CMDs include developing and revising policies that define the coverage of medical procedures in their jurisdictions. The CMDs are the primary interface between physicians and MACs, and are typically available and eager to discuss issues of coverage or payment policy. Other duties of CMDs include determining the need for LCDs, ensuring the correct application of LCDs in the claims adjudication process, providing clinical guidance in questionable claims review situations, and providing input on national coverage and reimbursement policy issues.

GUIDELINES FOR LOCAL MEDICARE COVERAGE

Title 18, § 1862(a)(1)(A), of the Social Security Act authorizes CMS to pay for reasonable and medically necessary services on behalf of Medicare beneficiaries.[4] The phrase "reasonable and necessary" is the language that allows CMS and its local contractors to deny claims for services that are not considered medically necessary by local MACs[4]. Additionally, CMS has interpreted this language to mean that services it or its contractors consider experimental are not covered as well.

All CMDs and their staff members are responsible for developing local policy for the coverage of Medicare services. Historically, these LCDs have been distributed to the medical community through documents called Local Medical Review Policies (LMRPs). In 2003, the CMS required that contractors convert all existing LMRPs to LCDs by the end of 2005.

The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while some LMRPs contained categorical or statutory provisions as well. LCDs are binding only within the MAC's jurisdiction; however, contractors are required to have consistent policies for all states across their jurisdictions.

There are many reasons for the development of LCDs. These include provider education, data tracking, and correcting the aberrant utilization of particular services. Perhaps the most important reason these policies are developed is to control the utilization of frequently used or high-cost services when contractors noticed variability in the utilization of those services. In contrast to payers that use precertification processes to establish medical necessity, the Medicare system uses a retrospective denial system whereby claims must meet the established requirements or be denied. These requirements often include, but are not limited to, promulgation of national coverage guidelines, frequency of services or treatment limits, and diagnoses (ICD) for which services (CPT) will be covered.

As previously stated, the vast majority of Medicare coverage decisions are local. However, when present, CMS national coverage policy supersedes LCDs. The CMS publishes these national coverage determinations (NCDs) periodically on its website at https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Whereas LCDs are binding only within a MAC's jurisdiction, NCDs are binding on all contractors and states. If an NCD exists for a certain procedure or group of procedures, MACs may also create LCDs on the same topic, but those policies must not contradict the NCD. On the other hand, if a MAC wishes to expand coverage to indications beyond those outlined in the NCD, generally it may do so, provided the national decision does not specifically limit those particular indications.[6]

The frequency of many procedures and treatments is limited by local and national coverage determinations. Importantly, local contractors can establish frequency limitations for both diagnostic tests and treatment procedures when there are no national coverage guidelines.

Another very important mechanism MACs use to limit the utilization of services is retrospective denials based on the reasons for those services. As previously stated, the Social Security Act mandates that all care provided to Medicare beneficiaries must be "reasonable and necessary." To ensure that

providers are aware of circumstances that contractors deem reasonable and necessary, each LCD contains a section of the indications that support medical necessity for the service or treatment. Occasionally, a contractor may reiterate limitations or circumstances under which a particular service will not be covered. This might include circumstances in which the contractor will determine a procedure to be experimental.

Although the indications section of the policy is typically general in its scope, the most important part of an LCD is the list of covered diagnoses. These lists use the ICD- 10-CM coding system to describe the covered diagnoses or symptoms, and any other diagnosis or symptom not on this list is typically not covered and therefore not reimbursed by the contractor. It is important for pathologists to be aware of the set of covered indications for each service they perform. *Note: this may be changing as a result of Program Integrity Manual changes.*

It is extremely important for CAC representatives to be attentive to the list of covered diagnoses for each service to ensure that the list of ICD codes will be complete, so that all medically necessary services are covered.

CONTRACTOR ADVISORY COMMITTEE (CAC)

In 1990, Congress created the CAC to serve as a representative advisory body for Medicare contractors. The CACs are comprised of physician representative from listed specialty groups (which include pathology) as well as representatives from medical societies and other relevant entities. The CAC acts as a liaison in representing the opinions of the profession and provides advice and comment to Medicare contractors in the development of LCDs.

Each MAC is required to establish one CAC per state or have the option of establishing one CAC per geographic jurisdiction with representation from each state in the jurisdiction. MACs have the discretion to determine the frequency of the CAC meetings and base the meetings on the appropriateness and the volume of LCDs that require CAC consultation as part of the LCD process. All CAC meetings are open to the public to attend and observe. MACs must record (video, audio or both) the CAC meetings and as part of the LCD record, assure the recording is maintained on their contractor website. In addition to CAC meetings, an additional Open Public Meeting is also required, at which representatives from industry and the general public can voice their comments and concerns about pending LCDs.[7]

Contractors are required to post LCDs on their web sites as well as the Medicare Coverage Database located on the CMS Web site: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. The CMS Coverage Database allows one to search for specific LCDs and NCDs by state and/or by topic. In addition, contractors must provide minimum comment and notice periods of 45 days each for all new LCDs and all revised LCDs that either restrict existing LCDs or make "substantive" corrections.[10] This allows CAC representatives a chance to provide input into the development of policies and ensure that the clinical practice of medicine is accurately represented.

LCD DEVELOPMENT PROCESS

CMS requires that contractors notify providers when the development of LCDs is in progress. There is a 45-day comment period during the development process. Then there is a 45-day notification period before final LCD implementation.

At the end of the comment period, the CMD takes the discussion of the draft LCD, reviews the written comments, and prepares the final LCD that must be distributed to all providers for the 45-day notice period before it is put into force.[8] After the close of the comment period and the required meetings and consultation, the MACs publish the final LCD and a Response to Comment (RTC) Article on the Medicare Coverage Database.

Once the appropriate set of diagnosis codes are established for an LCD, the codes are incorporated

into the MAC's claims-processing software. All claims for a service covered by an LCD submitted without a proper ICD code are denied. However, the final LCD is not always the final word regarding the diagnosis code set for a particular procedure. Medicare rules allow a CMD to add ICD diagnosis codes to the diagnosis code set without comment from the CAC. This allows appropriate codes that were omitted from the original list to be added, without the burden of formal comment and notice periods or other administrative issues. However, if the CMD elects to remove a diagnosis code from the code set, he or she is required to bring the revised LCD back to the CAC for comment.[9] Bringing forward omitted ICD codes for an LCD is a typical responsibility for a CAC member.

THE ROLE OF CAC REPRESENTATIVE

The CAC is composed of a representative from each major medical specialty. Therefore, in pathology, there are seats for 50 pathology CAC representatives advising the CMS, through its local contractors, on local coverage issues.

CMDs rely on their CACs for helping develop and understand the details of a service or procedure and the evidence used to determine coverage of those services or procedures. By reviewing evidence and commenting on LCDs and policy changes before they are implemented, pathology representatives can exert considerable influence on reimbursement policies in their local regions.

In the preparation of comments for the CMD, CAC representatives must review LCDs, which often have many ICD-10 codes. The duty of the CAC representative is to identify appropriate diagnoses or symptoms that have been omitted from the list proposed by the CMD. When the CAC representatives find additional diagnosis or symptom codes that should be added to the LCD, they may cite medical literature, specialty society publications, LCDs from other jurisdictions, or claims data as evidence for the inclusion of these additional ICD codes in the diagnosis set. Such documentation is typically appreciated by the CMD. In addition, having a consensus from the other CAC members is also important in supporting addition of ICD codes to the diagnosis set. Policy review, identification of relevant literature, and other documentation can be difficult and time consuming for practicing physicians. As such, the value of engaged and responsible CAC representatives to all practicing physicians cannot be overstated. In support of such pathologists who are willing to dedicate their time and efforts to these activities, the CAP undertakes outreach to pathology CAC representatives through its Coverage Program.

A good working relationship between the CAC representative and the local CMD is invaluable for affecting change at the local level. Pathology CAC representatives are strongly encouraged to:

1. Forward all draft/revised LCDs to the CAP staff as soon as they become available.
2. Attend CAC meetings and disseminate relevant coverage information with CAP staff. (When unable to do so, representatives can usually either participate by phone or designate an alternate member to attend).
3. Provide input on Medicare policy decisions that impact pathology coverage.
4. Discuss conflicting or inconsistent Local Coverage Determinations.
5. Collaborate with other CAC representatives in your MAC jurisdiction, to present a unified voice on coverage issues.

As these relationships are created and maintained, it becomes easier for pathologists to influence policies under development, and to revise errors in existing policies.

LCDs CAN LEAD TO VARIABILITY IN COVERAGE AMONG JURISDICTIONS

The final outcome of the LCD development process is a document that leads to the denial of coverage for a procedure if certain conditions are not met. Once the local Medicare contractor publishes the LCD, it is up to the providers of the services to be familiar with it and submit claims under those rules. If the conditions in the LCD are not met, then the Medicare contractor will deny the claim. Certain reasons for denial are national in scope. When a CMS NCD exists, all contractors

are required to follow that guideline for provider payment.

The vast majority of coverage decisions, however, are local and include limits on the frequency of procedures and the ICD diagnosis code set. This can lead to significant variability in coverage among MAC jurisdictions. As a result of these inconsistencies, the US Government Accounting Office strongly urges CMS to adopt national medical review policies to provide equal access to all beneficiaries. But the CMS stated they do not have adequate resources to develop national coverage policies for the large number of new procedures that are developed each year. Moreover, they found the provider community believes that local policies provide flexibility for Medicare contractors to address local concerns in a timely manner.

REQUESTING REVISIONS TO LCDS

If a physician feels that an LCD is inaccurate or that it should be revised, there is a formal process for requesting revisions to policies. Physicians must include justification for the change, including relevant published information, with reconsideration requests. Within 60 days, MACs are required to respond to a request for reconsideration as to whether a request is valid or invalid and may ultimately retire the policy, revise the policy, or make no revision to the policy. No changes to an LCD that make the policy more restrictive can be undertaken by the MAC without notification and comment from the CAC.[11]

CAP SUPPORT FOR PATHOLOGY CAC REPRESENTATIVES

The CAP is committed to providing as much assistance as possible to each pathology CAC representative through its Coverage Program. The CAP facilitates the identification, review, and development of comments on draft LCDs, and provides information and resources to CAC representatives and state societies within the appropriate MAC jurisdiction. The CAP's LCD Advisory Panel, consisting of members from the Council on Government and Professional Affairs (CGPA) and the Council on Scientific Affairs, (CSA), is the program's advisory body on all pathology-related LCDs that the CAP reviews and is a source of expertise relevant to each subspecialty area.

The CAP maintains a Medicare Coverage Program webpage on the CAP Advocacy website with valuable Contractor Advisory Committee information including links to the CMS LCD database, Medicare contractor directory, regional Medicare jurisdiction map, and much more.

SUMMARY

Federal law provides a unique opportunity for providers to influence Medicare coverage at the local level. By mandating that contractors have physician-based CACs, physicians have access to the Medicare coverage decision process that is superior to that of the private payers.

The LCD remains the most important part of the Medicare coverage process, having a direct impact on reimbursement for physician services provided to Medicare beneficiaries. Pathology CAC Representatives, and the CAP support system for assisting them, provides an excellent mechanism for pathologists to influence local Medicare payment policy, for the benefit of their colleagues, in the practice of pathology, in other specialties and ultimately for the public.

REFERENCES

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