Local Versus National Medicare Coverage

The Medicare statute states that items and services provided to beneficiaries must be “reasonable and necessary” to be covered for reimbursement to physicians, hospitals, and other providers. Although the Medicare program may determine in specific cases whether a particular item or service was reasonable and necessary, it also issues policies, called coverage determinations, to instruct carriers and other intermediaries regarding reimbursement to providers.

Local coverage determinations (LCDs) are still more common than national coverage determinations (NCDs), although national policies are now issued more often than in the past.

The principal function of an LCD is to advise providers and practitioners when particular items and services will not be considered reasonable and necessary. The policies may also make clear when coverage is available. According to the Medicare Program Integrity Manual, LCDs can be issued when there is a validated widespread problem involving high dollar or high volume services; an LCD is necessary to assure beneficiary access to care; or frequent denials are issued or anticipated as a result of postpayment claims review.

Contractors must follow a specified procedure to issue an LCD. They must hold a public meeting to discuss a draft LCD; the draft must be distributed to medical groups, posted on the contractor’s Internet site, and, in the case of an LCD proposed by a carrier, presented to the Carrier Advisory Committee; a 45-day period for public comment must be permitted; and the contractor must post a summary of the comments received and its response to those comments when finalizing the LCD.

The existence of LCDs means that Medicare coverage varies depending on the geographical area involved. Many observers have long regarded differences in local coverage policies as incompatible with a national Medicare program, but resource limits at the national level have kept development of many policies at the local level. The ongoing consolidation of the carriers and intermediaries into 15 Medicare administrative contractors should lessen some of the differences, as the new contractors adopt uniform policies throughout their areas. In addition, a law enacted in 2003 requires the Centers for Medicare & Medicaid Services (CMS) to review LCDs and determine which should be adopted nationally.

Until relatively recently, CMS issued only a handful of NCDs each year. However, congressional and public dissatisfaction with the lack of uniformity in Medicare coverage policy has led to significantly more national decisions. In addition, Congress has imposed deadlines on CMS to respond to requests for NCDs.

CMS typically considers issuing an NCD in several situations: when there are conflicting local policies on a significant issue; when there is a new procedure or medical device that may warrant coverage but many contractors are not covering it; when the utility of a procedure is in dispute; when new information indicates that existing coverage for a service should be terminated; and when there is over-utilization of a service.

The procedure for development of an NCD ordinarily begins with the CMS staff reviewing the scientific literature and otherwise evaluating the issue. This process may lead to CMS commissioning development of a formal technology assessment by an external contractor and referral of the matter to the Medicare Evidence Development and Coverage Advisory Committee. Based on this process, CMS issues a preliminary decision memorandum for public comment, and after review of the comments, issues a final decision memorandum that responds to the comments and reaches final conclusions. Eventually, the final decision memorandum is converted into an NCD.

Until recently, LCDs and NCDs could not be challenged directly. The only method for opposing a final LCD or NCD was to submit a claim for a service ruled noncovered in the policy, obtain a denial of the claim, and appeal the denial through the administrative process and, if necessary, in the courts. A successful appeal, however, would not invalidate the policy but only require payment of the claim.

Congress passed legislation allowing challenges to LCDs and NCDs in certain circumstances. Only a beneficiary in need of a noncovered service, or who has received a noncovered service, can take advantage of this procedure, although physicians and others can assist in the appeal. The appeal is initially to a Department of Health and Human Services administrative law judge or appeals board outside CMS, and if the administrative appeal is denied, the beneficiary can appeal in the courts. If the LCD or NCD is found to be unreasonable, it is invalidated.

Coverage policies can have a great impact on patients. As a practical matter, denying Medicare coverage for particular services denies patients access to those services. Concern about the importance of coverage policies has led to significant procedural requirements for issuing policies, initiatives for greater national uniformity of policies, and an appeals procedure.

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