Comments on LCDs

There is already a requirement that MACs notify providers of new or certain revised LCDs before they are published. It can be found in IOM 100-08, Chapter 8, section 13.7:

> 13.7.2 – LCDs That Require a Comment and Notice Period (Rev. 71, 04-09-04)
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> Contractors shall provide for both a comment period and a notice period in the following situations:
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> - All New LCDs
> - Revised LCDs that Restrict Existing LCDs - Examples: adding non-covered indications to an existing LCD; deleting previously covered ICD-9 codes.
> - Revised LCDs that make a Substantive Correction - If the contractor identifies an error published in an LCD that substantively changes the reasonable and necessary intent of the LCD, then the contractor shall extend the comment and/or notice period by an additional 45 calendar days.
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> 13.7.3 - When a comment and notice period is unnecessary, contractors may immediately publish a revised LCD electronically. There are several examples of revisions that don't require comment and notice, including revisions that actually expand coverage or revisions that result in non-substantive changes (e.g. correction of a typo)
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> 13.7.4 - **Comment and Notice Period** is defined as "When a new or revised LCD requires comment and notice (See §13.7.2) contractors shall provide a minimum comment period of 45 calendar days on the draft LCD. After the contractor considers all comments and revises the LCD as needed, the contractor shall provide a minimum notice period of 45 calendar days on the final LCD."

Therefore, I am concerned that simply asking for notification of new LCDs or updates won't result in any change, as CMS can reply that such notification is already required. However, that does not mean the notification is effective. Following are some examples of what I would comment:

- The language in the manual is outdated and may not be understandable to someone who has not been part of the changes CMS has made to the process over the years – for example, the manual still refers to "Carriers" rather than "MACs."

- Just because notification is required doesn't mean that the requirements are always followed by the Medicare contractors. There should be some way to address when this has not been done.

- In addition, the current methods of notification (e.g. through CACs) may not be the best way of keeping providers informed. It is complicated and too reliant on a changing group of volunteers from each specialty to attend a meeting, argue for any needed changes and get the word out to all members of his or her specialty.

- The process for requesting a “reconsideration” of an LCD seems too unwieldy. Rather than having a couple of pages of instructions explaining what a “reconsideration” is, how to request one, where and in what manner, accompanied by what documents, etc. it would seem simpler to just note something like “If a provider believes that something in an LCD is incorrect or unclear, he or she may request the MAC to review that portion of the LCD and to make any warranted changes accordingly. The request should explain what the provider feels needs to be changed and why. If it concerns a clinical change, the provider should send along credible evidence or links to credible evidence. The request can be sent to________ (e-mail address) and will be responded to within 30 days.”

- I don’t think everyone understands the subtleties of an LCD. For instance, an LCD only discusses why something is not covered if it doesn’t meet reasonable and necessary conditions, but doesn’t discuss items or services that aren’t covered because they are 1) excluded by law (statutory exclusion) or 2) don’t fall within a bucket of services listed as covered services under the Social Security Act (benefit exclusions.) This may be due in part to CMS switching from LMRPs to LCDs. I think it would be more helpful to have the LCDs at least include links to where providers can obtain additional information on some of these are reasons for non-coverage.

- There can be inconsistency in how various items or terms are interpreted and this is not always addressed in LCDs. For example, one MAC’s perception of what therapy services are medically necessary may differ from another MAC’s interpretation. This can also be a problem when a MAC either doesn’t have an LCD in a given area, or does not address the issue in their LCD. A good example of this is WPS’s denial of physician visits to SNFs. There is no LCD, and the reasons given for denial are not always specific enough, which makes it difficult to appeal denials. A request was made for them to publish an LCD and they declined.

- LCDs are not always written by or interpreted by staff with sufficient experience/understanding/knowledge related to a specialty area. A lot of things in medical practice don’t lend themselves to simple yes or no, black or white, determinations. An example might be in application of therapy caps or arbitrary limitations on therapy when a patient is not making “progress” but is merely maintaining status or not losing function as rapidly as they would without the therapy. The issue of coverage for so-called “maintenance” therapy took a court order to resolve (Jimmo vs. Sebelius) and according to the Center for Medicare Advocacy, there continue to be problems in how the judicially mandated interpretation is carried out. This could be due to reviewers’ misunderstanding of functional concepts related to rehabilitation.