YOUR CARRIER ADVISORY COMMITTEE NETWORK
(AND OTHER
MEDICARE-RELATED COVERAGE ACTIVITIES)

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• …and all the CAC members from all 50 states
• No financial disclosures or conflicts of interest
• Member Board of Trustees Medical Faculty Associates of George Washington University
• Voting Panel Member Medicare Evidence Development and Coverage Advisory Committee
COVERAGE POLICIES

- PQRS
- MOC
- PCORI

MORE AUDITS

- MIS-VALUED CODES
- NEW CPT’s

BUNDLED PAYMENTS

VALUE-BASED- MODIFIERS

ACO’s

ACR

CMMI
COVERAGE AND PAYMENT CASCADE

FDA approval → CPT level III code → CPT level I code → RUC valuation of code (USPSTF eg. CTC, LDLCS, mammo) → Coverage (CMS/pvt payer)
ACR MEDICARE-RELATED ACTIVITIES

- CAC network is representative of all 50 states
- Monitoring policies, comparison across jurisdictions, advising…
- LCD’S (Local Coverage Determination) (50-80/yrs.)
- NCD’S (National Coverage Determination)
- AUDITS-CERT, MAC, RAC
- Work with specialty committees like colon/lung cancer
Most advanced imaging is covered under LCD’s
MAC’s DEVELOP LCD’s
MAC’s DEVELOP LCD’s

Consolidated A/B MAC Jurisdictions
Novitas Solutions, Inc. (Novitas) proudly serves as an administrative services processing company for government-sponsored health care programs on behalf of the federal government. We employ more than 1,000 staff in the Mechanicsburg and Harrisburg, Pa. areas. Nearly 1,000 other associates are located in field offices in Hunt Valley, Md.; Pittsburgh and Williamsport, Pa.; Dallas, Texas; Milwaukee, Wis.; and Jacksonville, Fla. Novitas currently administers:

- The Medicare Administrative Contract (MAC) Jurisdiction L (IL), which spans four states and Washington D.C.;
- The Medicare Administrative Contract (MAC) Jurisdiction H (OH), which spans seven states, Indian Health Service (IHS) and Veterans Affairs (VA); and
- The payment processing for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens contract, as authorized under Section 1011 of the 2003 Medicare Modernization Act.

Click one of the images below to visit our provider websites for each of our contracts:
LCD’s are “local” policies, but must be “reasonable and necessary”
LCD’s are “local” policies, but must be “reasonable and necessary”

LCD L31399 - Magnetic Resonance Angiography (MRA)

MRA (MRI for Blood flow) Covered Indications

Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. Coverage is limited to MRA units that have received FDA premarket approval, and such units must be operated within the parameters specific to the approval. In addition, the services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved. (CMS Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 220.2.B.2).

Head and Neck

Studies have proven that MRA is effective for evaluating flow in internal carotid vessels of the head and neck. However, not all potential applications of MRA have been shown to be reasonable and necessary. All of the following criteria must apply in order for Medicare to provide coverage for MRA of the head and neck:

- MRA is used to evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries or the venous sinuses;
- MRA is performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion or thrombosis. Within this broad category of disorders, medical necessity is the underlying determinant of the need for an MRA in specific diseases. The medical records should clearly justify and demonstrate the existence of medical necessity; and,
- MRA and CA are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests. (CMS Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 220.2.B.2a).
LCD’s are “local” policies, but must be “reasonable and necessary”
WHERE ARE WE WITH LCD’s?

- Over-arching issues are: MAC consolidation and ICD-10
- As MAC’s consolidate, need LCD uniformity across jurisdiction. Means combining LCD content in some cases. If substantive change, MAC is usually posting for comments
- Some MAC’s have reduced number of LCD’s (in anticipation of having less LCD’s to convert by October 1, 2015?) These likely will resurface as new policies with ICD-10.
- For new or existing policies, verifying that the MAC accurately converted to ICD-10 is challenge; RBMA is developing a database to help review and vet proposed ICD-10-based LCD’s (Remember decision support too)
“reasonable and necessary for the diagnosis or treatment of an illness or injury within the scope of a Medicare benefit” (as opposed to safe and effective)

“NCD’s are made through evidence-based process... with public participation. In some cases CMS’ own research is supplemented with an outside technology assessment and/or consultation with MEDCAC “ (expert panel convened to advise CMS)
NCD’s CURRENTLY IN EVOLUTION

- CTC-awaiting re-review by USPSTF
- PET/CT non-FDG/non-NaF oncologic radiopharmaceuticals, after FDA approved, allow development of LCD’s
- FDG for oncologic applications-lift CED restriction for all cancers except prostate. Limit to 3 post-rx scan
- Beta-amyloid detection-CED coverage
- Carotid stenting (No NCD-equivocal MEDCAC panel)
- Defining role for CED (Coverage with Evidence Development)-Medicare population, generalizability, outcomes, etc.
NCD’s CURRENTLY IN EVOLUTION

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CTC
CTC

“There is insufficient evidence on test characteristics and performance of screening CT colonography on health outcomes in Medicare aged individuals. The results from the published studies on younger screening populations are not directly generalizable

CMS May 12, 2009
2012 MEETING WITH CMS
Focused on 3 Issues:
Medicare generalizability
ECF’s Dose

2013 USPSTF
NCD’s CURRENTLY IN EVOLUTION

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Decision Memo for Positron Emission Tomography (CAG-00065R2)

Decision Summary

The Centers for Medicare & Medicaid Services (CMS) has determined that, unless there is a specific national coverage determination, local Medicare Administrative Contractors (MACs) may determine coverage within their respective jurisdictions for positron emission tomography (PET) using radiopharmaceuticals for their Food and Drug Administration (FDA) approved labeled indications for oncologic imaging.

The effect of this decision is to remove the national noncoverage for FDA approved labeled oncologic uses of radiopharmaceuticals that are not more specifically determined nationally. Thus, this decision does not change coverage for any use of PET using radiopharmaceuticals FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)), NaF-18 (fluorine-18 labeled sodium fluoride), ammonia N-13, or rubidium-82 (Rb-82). This decision does not prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local contractor determination.
NCD’s CURRENTLY IN EVOLUTION

• CTC-awaiting re-review by USPSTF
• PET/CT non-FDG/non-NaF oncologic radiopharmaceuticals, after FDA approved, allow development of LCD’s
• FDG for oncologic applications-lift CED restriction for all cancers except prostate. Limit to 3 post-rx scan
• Beta-amyloid detection-CED coverage
• Carotid stenting (No NCD-equivocal MEDCAC panel)
• Defining role for CED (Coverage with Evidence Development)-Medicare population, generalizability, outcomes, etc.
Decision Memo for Positron Emission Tomography (FDG) for Solid Tumors (CAG-00181R4)

A. The Centers for Medicare & Medicaid Services (CMS) is ending the requirement for coverage with evidence development (CED) under §1862(a)(1)(E) of the Social Security Act (the “Act”) for $^{18}$F fluorodeoxyglucose positron emission tomography (FDG PET) for oncologic indications which are contained in section 220.6.17 of the Medicare National Coverage Determinations Manual. This removes the requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for those cancers or cancer types that had been covered under CED (as listed in Appendix A).

B. CMS has determined that three FDG PET scans are covered under § 1862(a)(1)(A) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anticancer therapy. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-tumor therapy will be determined by local Medicare Administrative Contractors.

Up to 3 scans covered for subsequent management of treatment
NCD’s CURRENTLY IN EVOLUTION

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- Beta-amyloid detection-CED coverage
- Carotid stenting (No NCD-equivocal MEDCAG panel)
- Defining role for CED (Coverage with Evidence Development)-Medicare population, generalizability, outcomes, etc.
Decision Memo for Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease (CAG-00431N)

Decision Summary

A. The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is insufficient to conclude that the use of positron emission tomography (PET) amyloid-beta (Aβ) imaging is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member for Medicare beneficiaries with dementia or neurodegenerative disease, and thus PET Aβ imaging is not covered under §1862(a)(1)(A) of the Social Security Act ("the Act").

B. However, there is sufficient evidence that the use of PET Aβ imaging is promising in two scenarios: (1) to exclude Alzheimer's disease (AD) in narrowly defined and clinically difficult differential diagnoses, such as AD versus frontotemporal dementia (FTD); and (2) to enrich clinical trials seeking better treatments or prevention strategies for AD, by allowing for selection of patients on the basis of biological as well as clinical and epidemiological factors.

Therefore, we will cover one PET Aβ scan per patient through coverage with evidence development (CED), under §1862(a)(1)(E) of the Act, in clinical studies that meet the criteria in each of the paragraphs below.

Clinical study objectives must be to (1) develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., frontotemporal dementia (FTD) versus AD) where the use of PET Aβ imaging appears to improve health outcomes. These may include short term outcomes related to changes in management as well as longer term dementia outcomes.
AUDITS

• The three audits that most target physician billing are:
  • CERT (Comprehensive Error Rate Testing)
  • MAC (Medicare Administrative Contractor review)
  • RA (Recovery Audits)
Be ready for much data mining in the future
RAC AUDITS (RA)

The RAC Review Process

- Claims selection targeted to claims that are most likely to contain an improper payment.
- The RAC requests medical records via paper letter.
- Reviews conducted by clinicians and certified coders.
- All Postpay (up to 3 years prior to date of service)
  - Over payments are recouped
  - Under payments are paid back
- Top issues are posted on [www.cms.gov/ra](http://www.cms.gov/ra)
- Providers file appeals at MAC

Targeted reviews, RAC paid percentage of recovered payment
Publish issues list in advance-high risk
Physicians and Hospitals
Limitations on number of Records requested
Tight timelines on appeal process
Rebuttal plus 3 levels of Appeal (MAC, QIC, Admin Law Judge)
## RAC CHANGES

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<thead>
<tr>
<th>Concern</th>
<th>Program Change</th>
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<tr>
<td>Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.</td>
<td>Recovery Auditors must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.</td>
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<td>Providers do not receive confirmation that their discussion request has been received.</td>
<td>Recovery Auditors must confirm receipt of a discussion request within three days.</td>
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<td>Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.</td>
<td>Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.</td>
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<td>Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in department within the facility.</td>
<td>The CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).</td>
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<td>ADR limits are the same for all providers of similar size and are not adjusted based on a provider’s compliance with Medicare rules.</td>
<td>CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider’s denial rate. Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.</td>
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ACR: lack of coordination, flawed methods, lack of transparency on details and process…and huge burden on practices

GAO: inconsistencies, inefficient, need better communication and time frames
A lot of challenges and opportunities lie ahead…