Taking the Mystery Out of LCDs and Medicare

It's important to understand how these local rules work.

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Most of us have heard the term LCD. We probably even know it means Local Coverage Determination. But how much more about LCDs do you really know? Exactly what are they? How are they made? How are they applied? How are they used in audits? How can they be challenged? We will explore all of this and more.

What Is a Local Coverage Determination?

The actual term is characterized by the Social Security Act as being determined by a Medicare Administrative Contractor, also known as a MAC. The MAC determines if a particular service or item is covered on a local basis (as in the area that the MAC covers) or not. Each region in our country is covered by a MAC. MACs process Medicare claims and develop LCDs for their respective regions. The LCDs are supposed to be based upon both the reasonableness of the service as well as its medical necessity.

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How Are LCDs Prepared?

In fact, LCDs can be prepared a bit like a sausage. Because of that, pursuant to the 21st Century Cures Act of 2016, the Congress directed the Secretary of the Department of Health and Human Services to increase the transparency of the LCD-making process. The following "roadmap" concerning the preparation of an LCD made use of Chapter 13 of the Medicare Program Integrity Manual, available online.

The first step may involve informal meetings of concerned parties, such as healthcare providers, insurance people, governmental people, and academics, as well as almost anyone else. The Manual states they are "educational" in nature, and not "pre-decisional negotiations". Of note, it restricts the interested parties to being within the MAC's jurisdiction.

For example, if the MAC was JH Novitas, the interested parties would

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be restricted to Texas, Oklahoma, Louisiana, and the other surrounding states covered by that MAC. The companies that run the MACs do change every so often. The Manual states that these informal meetings "will assure that all relevant evidence needed to review for coverage is submitted with the request for a formal review." However, no meetings are required. If you see that as a contradiction, you would be correct.

The next step would be formally requesting a new LCD. This can be done only by an interested party within that MAC's jurisdiction. If the new requested LCD is from a provider, patient, or "any interested party doing business in a contractor's jurisdiction", it must be considered. Note that wording. An insurance company located in New York, but doing business in Texas or Oklahoma, may suggest a new LCD within the territory covered by JH Novitas within its MAC territory.

However, a patient or healthcare provider outside this territory may not have their suggested new LCD considered. Assuming the APMA has members, and does business in Texas or Oklahoma, they could suggest a new LCD.

The new suggestion must be in writing, identify the benefit category, and delineate the new LCD language, with justification using peer-reviewed evidence. Copies of that evidence must be included. The party must explain "the design, purpose, and/or method, as appropriate" of the suggested request. Remember, it must be based on evidence-based reasons.

Within 60 days, the MAC must rule if the request for a new LCD has followed the above rules and is complete. The MAC will inform the requester if it is complete, or if not, what is missing.

Before any official drafting of an LCD, the MAC must add to the research performed by the requester, any Clinical Guidelines, or recognized expert opinions relevant to the area in question, and medical associations, such as the APMA, for their relevant opinions.

Next comes the actual proposed LCD. There must be publication of the proposed LCD, an open meeting about the proposed LCD, a chance for public written comment, and a 45-day notice to the public, prior to its proposed effective date. While there are exceptions to this procedure, such as "compelling reasons", they are beyond the scope of this article.

Proposed Determination of LCD

Your local MAC prepares the proposed LCD determination as to any change in coverage, such as a limitation, additional coverage or non-coverage of a service or item. The MAC will then announce its determination via its Medicare Coverage Database (MCD). There will be a minimum of 45 days for public comment. It becomes apparent that someone from your professional organization should be monitoring proposed LCDs on the MCD that might affect your practice. When that occurs, it would behoove you and your fellow members to comment on the proposed LCD during the public comments period. Comments should be professional and evidence-based whenever possible.

There must 45 days' notice to the public that a local policy change will go into effect. In short, the new local policy is the local MAC's decision to cover or not cover or limit coverage of a particular item or service. It must be published in the Medicare Coverage Database (MCD) for all to see. This must include all comments that were posted and the MAC's response to the comments, as well as a summary of the evidence used by the MAC during this process. A proposed new LCD, if not finalized within one year, is automatically withdrawn. A proposed new LCD, if not finalized within one year, is automatically withdrawn.

Challenging an LCD

An LCD can be challenged by almost anybody—that includes you, the medical provider. In your challenge, you must include your name, address, your phone number, your provider number, the name of the LCD you are challenging, your email address, the health insurance claim number involved in your challenge, and the specific part of the LCD that has impacted you, along with a statement explaining why in your case, the LCD is not correct and your reasons for challenging it. It should involve medical necessity. Citing evidence-based studies will be helpful.

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Examining an LCD for Debridement of Mycotic Toenails

Type in "Medicare LCD lookup" in almost any search engine, such as Google or Safari. It will take you to the Medicare LCD search cite. You can search by topic and/or location. If you type in "Debridement of Mycotic Toenails", LCD A56640 will pop up. It lists the contractors and states that are covered by this LCD. In this case, the list is quite long. Make sure that it covers your state and contractor. Beware, as not all contractors cover the entire state. Next, you are told the article type. In this case, it is about billing and coding of mycotic toenail debridement. It tells you the effective date. You will note that it has not been retired, meaning no longer valid. That means if you are in the part of the state covered by one of the listed contractors, this LCD governs when it comes to coding for the debridement of mycotic toenails. For the national policy, it refers you to another LCD; in this case, LCD L35013. You can easily obtain that LCD within this same website.

According to the "Article Guid-

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ance" section, L35013 will tell you the national policy as to the "reasonable and necessary requirements" to bill for 11720 and 11721, as well as the "frequency limitations." The next section is entitled "Coding Information". This describes what the two debridement codes are and a description of each. Then, it lists and explains the various ICD-10-CM codes that can be used (or not) to justify the debridement of the toenails. The LCD then goes on to list how it has been revised over time. If you read all of this, you will have a reasonably thorough knowledge of how and when to bill for the debridement of mycotic toenails in the area where you practice.

Concerning the debridement codes for toenails, do not lose sight that the treatment must be "reasonable and necessary" to treat or improve the illness or functioning, in this case, of the feet. In your patient records, there must be clinical evidence of how you made the diagnosis of mycotic toenails and that the thickness or shape of the nail or nails is markedly impairing the patient's ability to walk. Perhaps the pain from the pressure of the thick toenails, or the inability to put a shoe on due to the shape and thickness of the toenails, does not allow the patient to ambulate well. As with any other treatment code, when dealing with LCDs, do not neglect the national rules.

Definitive treatment of mycotic toenails also involves the use of a prescription anti-fungal medication, used as approved by the Federal Food and Drug Administration. Remember that just "clipping" the distal part of an onychauxic, mycotic toenail is not sufficient to be reimbursed. The entire part of the toenail that shows mycotic clinical changes must be debrided. Your chart should state that, as long as that is accurate.

There you have it. LCDs are a means for localities to further define, limit, or allow various treatments. Recently, the federal government has attempted to make the process more accessible and transparent to the public. To take advantage of this process, you must be knowledgeable about how it works and how you may participate in it. **PM**

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