

**Report to Congress on  
National Coverage Determinations  
For Fiscal Year 2009**

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This is the ninth annual Report to Congress on Medicare's national coverage determinations (NCDs) for the Centers for Medicare & Medicaid Services (CMS). Consistent with section 1869(f)(7) of the Social Security Act (the Act), CMS reports the amount of time it takes to complete and implement all NCDs (including NCDs for items and services not previously covered as a benefit) made between October 1, 2008, and September 30, 2009. In fiscal year (FY) 2009, CMS continued to meet the deadlines set by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, with an average time of just over 6 months from the date of a formal request to the date of publication of the proposed decision memorandum (DM). It took an average of 77 days from date of publication of the proposed DM to the final DM. There was an average of an additional 127 days to fully implement the payment and coding changes for decisions to cover an item or service (coding changes occur on a fixed quarterly cycle).

Medicare payment is contingent on a determination that an item or service falls in a statutory benefit category, is not statutorily excluded from coverage, and in most circumstances, that the item or service is "reasonable and necessary." Section 1862(a)(1)(A) of the Act states that subject to certain limited exceptions, no payment may be made for any expenses incurred for items or services that are not "reasonable and necessary" for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member. For more than 35 years, CMS has exercised these authorities to make coverage determinations regarding whether specific items or services meet one of the broadly defined benefit categories and can be covered under the Medicare program.

#### **National Coverage Determinations (NCDs)**

As defined in section 1862(1) of the Act, an NCD means a determination by the Secretary with respect to whether or not a particular item or service is covered under this title XVIII. In general, an NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a particular medical item or service. An NCD is usually written in terms of a specific item or service that may receive (or not receive) Medicare payment. NCDs are binding on all Medicare Carriers, Fiscal Intermediaries, Medicare Administrative Contractors, Quality Improvement Organizations, Qualified Independent Contractors, Administrative Law Judges, and the Medicare Appeals Council.

Since multiple contractors' process and pay claims for more than 43 million beneficiaries, it takes time to communicate precisely how to implement these uniform national policies. Implementation may include technical, localized computer systems changes, and/or changes to multiple shared computer systems that involve all Medicare contractors and system maintainers. Beneficiaries are protected by the NCD's effective date, even if computer system edits are delayed. Medicare instructions include an effective date that establishes when items and services will be covered, as well as an implementation date indicating the last day contractors have to complete all required system edits.

In FY 2009, CMS implemented 9 NCDs.

**Statutory timeframes for completing NCDs**

- **6 months:** From a formal request to publication of the proposed DM (9 months for an external Technology Assessment {TA} or a Medicare Evidence Development & Coverage Advisory Committee {MEDCAC} meeting)
- **90 days:** From the date of publication of a proposed DM to release of a final DM

Table 1: Individual detail NCD, including the outcome of CMS review and the completion times.

	NCD type/result	Proposed DM <sup>1</sup>	Final DM <sup>2</sup>	NCD implemented <sup>3</sup>
<b>Decisions initiated in FY 2007 and implemented in FY 2009</b>				
Artificial Hearts	New, covered with conditions	6	90	214
<b>Decisions initiated in FY 2008 and implemented in FY 2009</b>				
Heartbreath Test for Heart Transplant Rejection	New, not covered	<6	70	119
Percutaneous Transluminal Angioplasty (PTA) of the Carotid Artery Concurrent with Stenting	Reconsideration, covered with conditions	6	75	104
Surgery for Diabetes	New, covered with conditions	6	87	95
Surgery on the Wrong Body Part	New, not covered	<6	44	172
Surgery on the Wrong Patient	New, not covered	<6	44	172
Thermal Intradiscal Procedures	New, not covered	6	76	98
Wrong Surgery Performed on a Patient	New, not covered	<6	44	172
<b>Decision initiated in FY 2009 and implemented in FY 2009</b>				
Sleep Testing for Obstructive Sleep Apnea (OSA)	New, covered with conditions	0 <sup>4</sup>	70	160
<b>AVERAGE</b>				

\* TA, \*\*MEDCAC, \*\*\* TA and MEDCAC

<sup>1</sup> Months elapsed from date of opening coverage issue to date of proposed DM posted on CMS Website.

<sup>2</sup> Days elapsed from date of proposed DM to date of final DM. (MMA requires that the final DM include changes made as a result of the 30-day comment period.

<sup>3</sup> Days elapsed from date of final DM posted on CMS Website, i.e. (policy effective date), to date of implementation instructions.

<sup>4</sup> Proposed DM posted on CMS Website same day coverage issue was opened.

## **Factors CMS Considers in Commissioning External Technology Assessments**

During the NCD process, CMS may determine that it needs assistance in evaluating the evidence. In many cases, this will be following the opening of an NCD (see Guidance Document on Opening an NCD, which is available on the CMS coverage website at the following address: [www.cms.hhs.gov/mcd/ncpc\\_view\\_document.asp?id=7](http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=7)). In other cases, CMS may determine that it needs an external Technology Assessment (TA) to evaluate the available evidence prior to deciding on the need for an NCD. Also, there may be instances where an external TA will help inform CMS on the status of the evidence on certain topics of interest to the Agency.

CMS explains the factors it considers in commissioning an external TA in its guidance document, which is available on the CMS coverage website at the following address: [www.cms.hhs.gov/mcd/ncpc\\_view\\_document.asp?id=7](http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=7).

In general, CMS may request an external TA if one of the following conditions applies:

- The body of evidence to review is extensive, making it difficult to complete an internal TA within the 6-month statutory timeframe
- An independent formulation of the appropriate assessment questions and methodological approach to an issue is desirable given the complexity or conflicting nature of the medical and scientific literature available
- Significant differences in opinion among experts concerning the relevant evidence or in the interpretation of data suggest that an independent analysis of all relevant literature will be of value
- The review requires unique technical and/or clinical expertise not available within CMS at the time of the review
- The review calls for specialized methods (e.g., decision modeling, meta-analysis) in health technology assessment
- The topic under consideration will be referred for consideration to the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC)
- Relevant non-proprietary but unpublished data could be collected and analyzed

## **Factors CMS Considers in Referring Topics to the MEDCAC**

CMS explain the factors it considers in referring a topic to the MEDCAC in its guidance document, which is available on the CMS coverage website at the following address: [www.cms.hhs.gov/mcd/ncpc\\_view\\_document.asp?id=10](http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=10).

In general, CMS may refer a topic to the MEDCAC under any of the following circumstances:

- There is significant controversy among experts. The opinions of clinical and scientific experts about the medical benefit of the item or service, the level of competence of providers, the requirements of facilities, or some other significant consideration that would affect whether the item or service is "reasonable and necessary" under the Social Security Act
- The existing published studies contain potentially significant methodological flaws such as flawed design, inappropriate data analysis, or small sample size
- The available research has not addressed policy relevant questions
- The available research has not addressed diseases and conditions or the special needs of the elderly in the Medicare population
- The existing published studies show conflicting results
- CMS would like additional expert review of the methods used in external TAs, particularly when there are questions about a TA, complex clinical issues, or specialized methods such as decision modeling
- CMS would like greater public input by receiving and considering comments on the effectiveness of an item or service that could be subject to varying interpretations. Obtaining the perspective of affected patients and caregivers (e.g., the degree of perceived benefit, subjective assessment of risk, or burden of side effects) through public comments and voting representatives on the panel may be relevant
- Use of the technology is the subject of controversy among the general public
- Presentation, public discussion, and clarification of the appropriate scope for the technical review, a preferred methodological approach, or a clinical management issue would benefit future NCDs
- Dissemination of a technology may have a major impact on the Medicare program, the Medicare population, or the clinical care for specific beneficiary groups