

Medicare Coverage Document Type Descriptions

Document Type	Description
LCD	<p>A Local Coverage Determination (LCD) is a decision made by a Medicare Administrative Contractor (MAC) on whether a particular service or item is reasonable and necessary, and therefore covered by Medicare within the specific region that the MAC oversees.</p> <p>MACs are Medicare contractors that develop LCDs and process Medicare claims. MACs develop an LCD when there is no national coverage determination (NCD) (e.g., when an item or service is new) or when there is a need to further define an NCD for the specific region.</p> <p>LCDs are specific to an item or service (procedure) and they define the specific diagnosis (illness or injury) for which the item or service is covered. LCDs outline how the contractor will review claims to ensure that the services provided meet Medicare coverage requirements.</p> <p>Before an LCD becomes final, the MAC publishes Proposed LCDs, which include a public comment period.</p> <p>LCD document IDs begin with the letter “L” (e.g., L12345). Proposed LCD document IDs begin with the letters “DL” (e.g., DL12345).</p> <p>The guidelines for LCD development are provided in Chapter 13 of the Medicare Program Integrity Manual. The Social Security Act, Sections 1869(f)(2)(B) and 1862(l)(5)(D) define LCDs and provide information on the process.</p>
Article	<p>Local coverage Articles are a type of educational document published by the Medicare Administrative Contractors (MACs). Articles often contain coding or other guidelines that complement a Local Coverage Determination (LCD).</p> <p>MACs are Medicare contractors that develop LCDs and Articles along with processing of Medicare claims.</p> <p>There are different article types:</p> <p>Billing and Coding articles provide guidance for the related Local Coverage Determination (LCD) and assist providers in submitting correct claims for payment. Billing and Coding articles typically include CPT/HCPCS procedure codes, ICD-10-CM diagnosis codes, as well as Bill Type, Revenue, and CPT/HCPCS Modifier codes. The code lists in the article help explain which services (procedures) the related LCD applies to, the diagnosis codes for which the service is covered, or for which the service is not considered reasonable and necessary and therefore not covered.</p> <p>Response to Comment (RTC) articles list issues raised by external stakeholders during the Proposed LCD comment period.</p> <p>Self-Administered Drug (SAD) List Exclusion articles list the CPT/HCPCS codes that are excluded from coverage under this category. The Medicare program provides limited benefits for outpatient prescription drugs. The program covers drugs that are furnished "incident-to" a physician's service provided that the drugs are not "usually self-administered" by the patient. CMS has defined "not usually self-administered" according to how the Medicare population as a whole uses the drug, not how an individual patient or</p>

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	<p>physician may choose to use a particular drug. For purpose of this exclusion, "the term 'usually' means more than 50 percent of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage" and the MAC will make no payment for the drug</p> <p>Draft articles are articles written in support of a Proposed LCD. A Draft article will eventually be replaced by a Billing and Coding article once the Proposed LCD is released to a final LCD.</p> <p>Articles are often related to an LCD, and the relationship can be seen in the "Associated Documents" section of the Article or the LCD.</p> <p>Article document IDs begin with the letter "A" (e.g., A12345). Draft articles have document IDs that begin with "DA" (e.g., DA12345).</p>
NCD	<p>National Coverage Determinations (NCDs) describe whether specific medical items, services, treatment procedures, or technologies are eligible for payment under the nationwide Medicare Program.</p> <p>Medicare coverage is limited to items and services that are considered "reasonable and necessary" for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Administrative Contractors (MACs) are required to follow NCDs.</p> <p>If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, an item or service may be covered at the discretion of the MAC based on a Local Coverage Determination (LCD). LCDs cannot contradict NCDs, but exist to clarify an NCD or address common coverage issues.</p> <p>Prior to implementation of an NCD, CMS must first issue a Manual Transmittal, CMS ruling, or Federal Register Notice giving specific directions to claims-processing contractors. That issuance, which includes an effective date and implementation date, is the NCD. If appropriate, the Agency must also change billing and claims processing systems and issue related instructions to allow for payment. The NCD will be published in the Medicare National Coverage Determinations Manual. An NCD becomes effective as of the date of the decision memorandum.</p>
NCA/CAL	<p>NCAs: National Coverage Analysis (NCA). When an NCD is under consideration, either a new review or a reconsideration, there are numerous documents that support the process. These documents are considered the NCA. They include tracking sheets to inform the public of the issues under consideration and the status (i.e., Pending, Closed) of the review, information about and results of MEDCAC (formerly known as MCAC) meetings, Technology Assessments, and Decision Memoranda that announce CMS's intention to issue an</p>

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	<p>NCD. These documents, along with the compilation of medical and scientific information currently available, any FDA safety and efficacy data, clinical trial information, etc., provide the rationale behind the evidence-based NCDs.</p> <p>CALs: Coding Analyses for Labs (CAL) is an abbreviated process, similar to the National Coverage Determination (NCD) process, for making changes to the coding component of the negotiated laboratory NCDs. The process is used for adjusting the list of covered (or non-covered) ICD-10 diagnosis codes and coding guidance in the NCDs when there is a question regarding whether the code flows from the narrative indications in the NCD. A tracking sheet is posted opening a CAL and a 30-day public comment period follows. A decision memorandum announcing and explaining the decision is posted following the comment period. Changes are implemented in the next available quarterly update of the laboratory edit module. More details regarding the process can be found in 68 FR 74607.</p>
MEDCAC	<p>The Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) process was established to provide independent guidance and expert advice to CMS on specific clinical topics. It is used to supplement CMS's internal expertise and to ensure an unbiased and contemporary consideration of "state of the art" technology and science.</p> <p>The MEDCAC reviews and evaluates medical literature, reviews technology assessments, public testimony and examines data and information on the benefits, harms, and appropriateness of medical items and services that are covered under Medicare or that may be eligible for coverage under Medicare. The MEDCAC judges the strength of the available evidence and makes recommendations to CMS based on that evidence. They advise CMS on whether specific medical items and services are reasonable and necessary under Medicare law. They perform this task in an open and public forum. The MEDCAC is advisory in nature, with the final decision on all issues resting with CMS. MEDCAC members are valued for their background, education, and expertise in a wide variety of scientific, clinical, and other related fields. In composing the MEDCAC, CMS was diligent in pursuing ethnic, gender, geographic, and other diverse views, and to carefully screen each member to determine potential conflicts of interest. More information can be found here: https://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=10&mcdtypename=Guidance+Documents&MCDIndexType=1&bc=gAACAAAAAAAA&</p>
TA	<p>Each National Coverage Determination (NCD) is supported by a comprehensive Technology Assessment (TA) process, which often focuses on the safety and efficacy of technologies.</p> <p>Health care Technology Assessment is a multidisciplinary field of policy analysis that studies the medical, social, ethical and economic implications of the development, diffusion and use of technologies. For some NCDs, external TAs are requested through the Agency for Health Research and Quality (AHRQ).</p>

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	For a description of the TA process and guiding principles for selecting which topics are referred for external TA assistance see https://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=7 .
Medicare Coverage Documents	Medicare Coverage Documents are published by CMS to help to relay information that is related to coverage on a national level. Examples include guidance documents, compendia, and solicitations of public comments.