MODEL LOCAL COVERAGE DETERMINATIONS: OPPORTUNITIES FOR COOPERATION IN THE HOUSE OF MEDICINE

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ABSTRACT

Given Medicare's position as the nation's largest payer for healthcare services, it is unfortunate that most physicians are unaware of the fact that the majority of Medicare's reimbursement decisions are made locally through "Local Coverage Determinations". Because distinct differences often exist among LCD's covering identical services, the ACC Carrier Advisory Committee, in cooperation with other professional societies, has developed "Model Local Coverage Determinations". The most recent Model LCD provides coverage recommendations for Cardiac Computed Tomography and Computed Tomographic Coronary Angiography. By joining together to produce model local coverage determination policies, our professional societies, governmental agencies and private payers have achieved a new standard of cooperation in improving health care.

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Model Local Coverage Determinations: Opportunities for Cooperation in the House of Medicine

It is unfortunate that most physicians are unaware of the fact that the majority of Medicare reimbursement decisions are made locally. The vehicle employed for the origination, provider review and dissemination of these decisions is called the Local Coverage Determination (LCD). The recently released Model Local Coverage Determination for Cardiac Computed Tomography (CCT) and Computed Tomography Coronary Angiography (CTCA) was prepared as a collaborative effort by the American College of Cardiology (ACC) Carrier Advisory Committee (CAC), American College of Radiology (ACR), American Society of Nuclear Cardiology (ASNC), North American Society for Cardiac Imaging (NASCI), Society for Cardiac Angiography and Interventions (SCAI) and the Society of Cardiovascular Computed Tomography (SCCT). Additional contributors included Empire Blue Cross Blue Shield Medicare Services and United Healthcare.

Given Medicare's position as the nation's largest payer for healthcare, ***all ACC members should be familiar with the process it employs for approximately seventy percent of its***

payment decisions. Each state has rights governed by the Social Security Act[1] giving the local Medicare fiscal intermediary (the carrier), the authority to determine coverage locally.

LOCAL COVERAGE DETERMINATIONS AND THE ACC CHAPTERS

Previously called Local Medical Review Policies (LMRP's), LCD's were defined in 2003 [2] as a decision by a local carrier to cover a particular service in accordance with the Social Security Act. All LMRP's were required to be converted to LCD's by the end of 2005. Medicare carriers determine whether an item or service is "reasonable and necessary" ***under specific clinical circumstances based on the input of medical and specialty societies***, and a review of current medical practice, clinical data and research studies.

Each Medicare carrier's medical director (CMD) is required to establish a Carrier Advisory Committee (CAC) consisting of representatives of all providers of Medicare services in the state and chosen by the provider's recognized professional society. ***For example, each state cardiology representative is selected by the ACC Governor.*** Each CAC elects a Cochairperson from its membership to serve with the CMD in conducting the Committee's functions.

Carrier Advisory Committees have only "Review and Advise" roles. ***It is the responsibility of each ACC CAC member to seek comment on proposed new or revised policies from informed members of College's state chapter for presentation to the CMD.*** In fulfilling this essential role, Fellows of the ACC have a major influence in determining the content of local cardiovascular coverage determinations.

PROFESSIONAL SOCIETY RESPONSE TO LCD's

Recognizing the value of increased communication among individual state CAC representatives of the same specialty, ***several professional societies have formed national categorical CAC's***. Ophthalmology was among the first specialty to create a national committee. More recently, similar committees have been created by other organizations, including the ACC and the ACR. Staffed by their national professional societies and consisting of representatives from each state, ***these national CAC's share common goals: 1) To bring greater uniformity across individual states' LCD's 2) To bring increased breadth and expertise to the LCD review process, and 3) To advocate for appropriate coverage determinations, including indications, limitations and competency recommendations.***

THE AMERICAN COLLEGE OF CARDIOLOGY CARRIER ADVISORY COMMITTEE

The ACC established its Carrier Advisory Committee in 2000 to become more proactive with local Medicare carriers in matters related to cardiovascular care. ***The ACC CAC is staffed nationally and functions as a sub-committee of the College Board of Governors***.

Meeting twice yearly, the ACC CAC welcomes representation from other cardiovascular subspecialty organizations and invites governmental agencies and private payers to share in the discussion and educational process. Typical agenda topics include member presentations of local coverage issues, updates on proper Coding and Nomenclature, reports from CMS on new or proposed coverage issues, Medicare contractor reform, the physician voluntary reporting program, and Medicare's Health Support Program/Chronic Care Improvement. ***It is expected that CAC members will transmit these discussions to their local chapter members.***

Over the years, the ACC CAC as grown into a forum for information exchange through which the cardiovascular specialty has strengthened its voice in promoting quality cardiovascular care. ***More recently, the ACC CAC has focused its efforts on developing model local coveragedeterminations.***

CREATION OF THE MODEL LOCAL COVERAGE DETERMINATION DOCUMENT

In 2001 the existence of ***marked variation in coverage*** for transthoracic echocardiography motivated the ACC CAC to develop "model" coverage policies for specific cardio-vascular services. These model policies are intended for voluntary use by local Medicare carriers and to serve as templates for policy discussions with private payers where applicable. To ensure validity, these models employ established clinical guidelines and are created in cooperation with other specialty societies. ***The choice of service topic is made by vote of the ACC CAC membership*** from those existing local LCD's having significant coverage variation and major economic implications. Upon selecting a topic, leadership within the CAC is identified, invitations are issued to other organizations, work groups are established, task forces are created for each LCD component, and specific expertise outside the CAC is sought where needed.

The ACC CAC's first document was the Model LMRP for Transthoracic Echocardiography, created in conjunction with the American Society of Echocardiography. Begun in 2001 and released in 2003, this was ***the first model policy to incorporate recommendations for appropriate*** laboratory accreditation, technician credentialing and ***physician competence***, topics not previously contained in Medicare LMRP's. This model was updated in 2004 and has been utilized in part or in whole by several Medicare carriers.

The ACC CAC's ***second document was the Model LCD for SPECT Myocardial Perfusion Imaging,*** created in conjunction with the American Society of Nuclear Cardiology and released in 2005.

A MODEL LCD FOR CARDIAC COMPUTED TOMOGRAPHY AND CT CORONARY ANGIOGRAPHY -
AN EXPANDED OPPORTUNITY FOR INTERSOCIETY COOPERATION

Because of the rapid pace of technology development in CTCA and intense interest by both the physician and payer community in establishing coverage and payment policy, the ACC CAC approved creation of a model LCD in March of 2005. Utilizing the methodology described, cooperation was obtained from ACR, ASNC, NASCI, SCAI, SCCT, Empire Blue Cross Blue Shield Medicare Services, and United Healthcare, and task forces were established for each section of the LCD. ***In December 2005, the model LCD for CCT and CTCA was released to all Medicare Medical Directors.***

Some have already employed the document in part in their Local Coverage Determinations. The document also may serve as a useful tool for private sector payers. Periodic revisions of the model LCD are anticipated.

CHALLENGES ENCOUNTERED IN CREATING A MODEL LCD FOR CCT AND CTCA

Although one might have anticipated competing interests among the participating organizations, concern for quality of patient care was paramount throughout the discussions. The participants' primary concern related to "Indications for Coverage and/or Medical Necessity" and the issue of levels of evidence versus patient access to promising new technology. This subject was a continual challenge. It was agreed that the model LCD was the beginning of an ongoing attempt to define the applicability of a new technology.

Indications offered by the model LCD are ***primarily based on expert consensus*** and it is anticipated that revisions will occur as higher levels of evidence become available. Early evaluation of new technology is often based on single center observational studies that may reflect an element of bias. Multi-center, randomized, controlled trials are rarely available. Given these realities, ***cooperation within the house of medicine is a valuable tool in achieving consensus that offers the best likelihood of quality patient care.***

FUTURE ENHANCEMENTS OF LOCAL COVERAGE DETERMINATIONS

Experience in drafting model LCD's has suggested several enhancements that may increase their value. These include:

- Inclusion of provider credentialing and competence.
- Inclusion of diagnostic imaging laboratory accreditation.
- Inclusion of appropriateness criteria.
- Cross modality efficacy estimates for new technology.
- Requirement for provider participation in registries where initial evidence of incremental value remains uncertain.
- Periodic LCD review and revision as relevant guidelines and appropriateness criteria are updated.

CONCLUSIONS

The existing legislatively mandated Medicare system of local coverage determination in an era of nationally recognized patient care guidelines and performance measures has created an exceptional challenge for cooperation among the multiple stakeholders dedicated to excellence in patient care. By joining together to produce model local coverage determination policies, ***our professional societies, governmental agencies and private payers have achieved a new standard of cooperation in their shared dedication to the ultimate goal of improved health care.***

References:
1) Title XVIII of the Social Security Act, Section 1862
(a)(1)(A)
2) Benefits Improvement and Protection Act, Section 522.