CMS Overview of Payment and Reimbursement Policy for People with ALS
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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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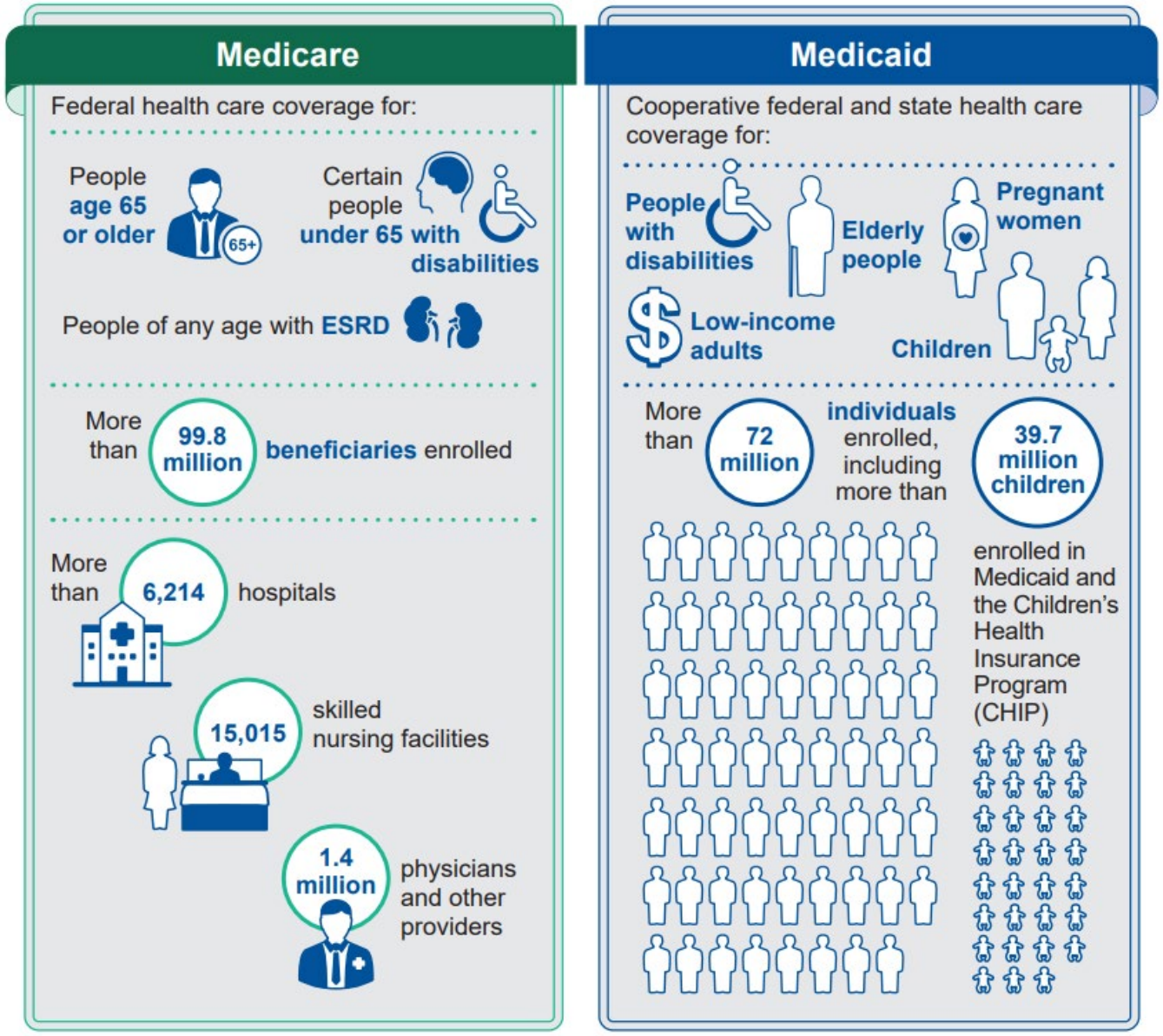
Objectives

- Describe reimbursement policy in the Medicare program
  - General overview
- Review coverage determination process
  - National Coverage Determination process
  - Local Coverage Determination process
- Resources

- **Medicare: Health insurance for people**
  - 65 and older, or under 65 with certain disabilities
    - ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) without a waiting period
    - Any age with End-Stage Renal Disease (ESRD)

- **Medicaid: Joint Federal and State health insurance program**
  - Helps pay health care costs for people with limited income and resources
  - May cover services that Medicare may not or may partially cover, like nursing home care, personal care, and home-and-community-based services
  - Medicaid programs vary from state to state, with different income and resource requirements



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProgramBasics.pdf

Medicare Options

Original Medicare

- ☑ **Part A**
- ☑ **Part B**

You can add:

- ☐ **Part D**

You can also add:

- ☐ **Supplemental coverage**

  This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

- ☑ **Part A**
- ☑ **Part B**

Most plans include:

- ☑ **Part D**
- ☑ **Extra benefits**

Some plans also include:

- ☐ **Lower out-of-pocket costs**

NOTE: Medicare Supplement Insurance (Medigap) policies only work with Original Medicare.

Medicare Coverage Determination Process

- Medicare coverage is limited to **items and services that are reasonable and necessary** for the diagnosis or treatment of an illness or injury

- National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation.
  - In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).

- In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD).

https://www.cms.gov/Medicare/Coverage/DeterminationProcess

National Coverage Determination (NCD)

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/howtorequestanNCD

- **Requesting an NCD is a formal process. In general, we will consider a request to be a complete, formal request if the following conditions are met:**
  - The request is in writing, is not marked as a draft, and is clearly identified as "A Formal Request for a National Coverage Determination."
  - The request clearly identifies the statutorily-defined benefit category to which the requester believes the item or service applies and contains enough information for us to make a benefit category determination.
  - The request is accompanied by sufficient, supporting evidentiary documentation.
  - The information provided addresses relevance, usefulness, or the medical benefits of the item or service to the Medicare population.
  - The information fully explains the design, purpose, and method of using the item or service for which the request is made.
- **Requests for NCDs may be submitted:**
  - Electronically to NCDRequest@cms.hhs.gov.
  - Via postal service, to the Centers for Medicare & Medicaid Services; Director, Coverage and Analysis Group; 7500 Security Boulevard; Baltimore, MD 21244.

Local Coverage Determination (LCD)

- Local coverage determinations (LCDS) are defined in the Social Security Act
  - “the term ‘local coverage determination' means a determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts, in accordance with section 1862(a)(1)(A).”

- CMS has revised the **Medicare Program Integrity Manual (PIM), Chapter 13** – Local Coverage Determinations (Pub 100-08), to guide the LCD process.
  - A step-by-step description of the LCD process
  - Outlines the processes used for informal meetings prior to the development of an LCD, external requests to develop an LCD, consultations, the proposed determination, public comment, the Contractor Advisory Committee (CAC), final determination, and the notice period

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf
https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs

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