90.3 – General Rules for NCDs

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

Medicare coverage policies specify which items and services are covered (or not covered) under Part A or Part B of the Medicare program and under what circumstances (including the clinical criteria under which the item or service must be covered). Medicare coverage policies have several sources:

- NCDs made by CMS;
- Local Coverage Determinations (LCDs);
- Legislative changes in benefits applied through notice and comment rulemaking (often codifying the changes in the Code of Federal Regulations); and
- Other coverage guidelines and instructions issued by CMS (e.g., Change requests and Program Transmittals).

As indicated in *section* 10.2 above, MA plans must provide all items and services classified as original Medicare-covered benefits. In applying this rule to NCDs, different rules apply depending on whether the significant cost criterion, described above in *section* 90.3, has been met.

90.3.1 – When the Significant Cost Criterion is Not Met

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When CMS determines that a NCD or legislative change in benefits does **not** meet a criterion for significant cost, the MA plan is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation. NCDs are effective on the date that CMS releases the Final Decision Memorandum for the NCD. The NCD effective date is the date when the new or changed benefit/service must be made available to enrollees by the plan. The implementation date in the corresponding Medicare Change Request (CR) /Transmittal guidance (TR) is the latest date by which MA plans must have payment system edits in place and coverage/non-coverage fully implemented for providers/suppliers. Plans must ensure that the items/services are covered, and provider claims paid, retroactive to the NCD effective

date. More information related to Medicare CR/TRs and manual guidance may be found in references provided in *section* 90.6 below.

90.3.2 – When the Significant Cost Criterion is Met
(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

Prior to the adjustment of the annual MA capitation rate, if CMS determines and announces that an individual NCD item, service or legislative change in benefits does meet a criterion for significant cost, then plans are not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:

- Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i),(ii));

- NCD items, services, or legislative change to benefits that are already included in the plan's benefit package either as original Medicare benefits or supplemental benefits.

Although the item or service may not be specifically included in the services MAOs must cover under their contract with CMS, MAOs must still provide access to the NCD item or service by furnishing or arranging for the service.

The MACs are responsible for reimbursements for NCD items, services, or legislative changes that are not the legal obligation of the MAO.

90.3.3 – Payment for NCD Items and Services
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Chapter 8 of the *MMCM*, "Payments to Medicare Advantage Organizations," contains the detailed rules on payment for NCD items and services or legislative changes in benefits that meet the significant cost threshold. That manual chapter includes a description of services for which MAOs are responsible. Enrollees are responsible for any applicable coinsurance amounts under original Medicare.

Once the annual MA capitation rate, or other payment adjustment, reflects the new costs, the service or benefit is considered included in the MAO's contract with CMS and is a covered benefit under the contract. The MAO must furnish, arrange, or pay for the NCD service or legislative change in benefits, subject to all applicable rules. MAOs may establish separate plan rules for these services and benefits, subject to CMS review and approval. CMS may, at its discretion, issue overriding instructions limiting or revising the MA plan rules, depending on the specific NCD or legislative change in benefits. For these services or benefits, the enrollee is responsible for any MA plan cost-sharing, as approved by CMS or unless otherwise instructed by CMS.