DOS Coding and Billing for Surgical and Anatomical Pathology Services

On September 19, 2017, the Centers for Medicare & Medicaid Services (CMS) released MLN Matters Number: SE17023 to provide coding and billing guidance for surgical and anatomical pathology date of service (DOS) on professional claims. However, it was immediately rescinded.

The following update references the Internet Only Manual Update to Chapter 16 (Section 40.8: Date of Service Policy effective January 1, 2018) of the Pub 100-04.

Surgical and anatomical pathology services can be split into either professional component (PC) or technical component (TC), each separately billable to the local Medicare Administrative Contractor (MAC) when not reported as a global service. The PC and TC components are reported to distinctly identify a split service performed by a physician or pathology laboratory. These services will have a PC/TC indicator of “1” on the Medicare Physician Fee Schedule (MPFS) Relative Value (RVU) File.

**PC and TC do not apply to physician or other qualified healthcare professional services that cannot be distinctly split into professional and technical components. Modifiers PC and TC may not be used with such billing codes.**

Noridian Healthcare Solutions

**Differences Between PC and TC**

Modifier PC (also referred to as modifier .26) is used with the appropriate CPT® code to report the supervision and interpretation portion of a diagnostic test (e.g., 88305—surgical pathology, gross and microscopic examination) and includes indirect practice and malpractice expenses related to that work.

Modifier TC appended to the appropriate CPT® code is used to report all nonphysician or qualified healthcare professional work and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses.

In practical terms, modifier TC is used to report the slide-preparation portion, while modifier .26 indicates the slide-reading portion.

**Choosing Appropriate DOS**

Generally, CMS states that the DOS of the test/service must be the date the specimen was collected. The following table explains when and how to apply the appropriate DOS. For more information about choosing appropriate DOS, visit [https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4000CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4000CP.pdf).
DOS Coding and Billing for Surgical and Anatomical Pathology Services

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<tr>
<th>Description of Service</th>
<th>Appropriate Billing Date of Service (DOS)</th>
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<tr>
<td>Technical Component (TC)</td>
<td>Billed on the date the surgery is performed (the date the specimen was collected)</td>
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<tr>
<td>Professional Component (PC)</td>
<td>Billed on the date when the physician or qualified healthcare provider provides the interpretation and report of the pathology service</td>
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<td>If PC and TC occur on different dates</td>
<td>Bill on different dates using the TC modifier for the technical component and modifier 26 for the professional component</td>
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<td>Collection of specimen spans two calendar dates</td>
<td>Use the date the specimen collection ended</td>
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Exceptions to DOS Policy: Stored specimens (stored less than or equal* to 30 calendar days) from collection date, the date of service must be the date the test was performed, only if:

- Test is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital
- Specimen was collected while the patient was undergoing a hospital procedure
- It would be medically inappropriate to have collected the specimen other than during the hospital procedure for which the patient was admitted
- Results of the test do not guide treatment provided during the hospital stay
- Test/service is reasonable and medically necessary for treatment of an illness

*Note: If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.

Source: Medicare Claims Processing Manual, Chapter 16, Section 40.8: Date of Service (DOS) for Clinical Laboratory and Pathology Specimens.

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CMS Releases 2019 First Quarterly CCI Edit Updates

The Centers for Medicare & Medicaid Services (CMS) develops, updates, and maintains the National Correct Coding Initiative (NCCI) Edits every quarter. This is a continued effort to promote national correct coding and control improper coding that can potentially lead to inappropriate payment for Part B claims.

These edits are based on CMS coding policies, use coding conventions defined in the American Medical Association’s (AMA’s) Current Procedural Terminology (CPT®) code set, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

NCCI PTP Edits

Developed to prevent improper payment when incorrect code combinations are reported, the NCCI procedure-to-procedure (PTP) edits allow for non-payment of healthcare insurance claims of services that should not be reported together.

Each edit has two columns: column one and column two of HCPCS/CPT codes paired on one line. If a healthcare provider reports a combination of the two codes in an edit pair for the same beneficiary on the same date of service (DOS), the code in the first column is eligible for payment but the code in the second column will be denied unless a clinically appropriate NCCI associated modifier is reported with that code.

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Editor’s Notes:

The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

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CMS Releases 2019 First Quarterly CCI Edit Updates

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CMS posts PTP and MUE quarterly updates to its NCCI PTP and MUE at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html.

Sample NCCI Edits

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Modifier 59’s Effect On Procedure Codes
Because dermatology services are reported with multiple procedures on the same DOS, use of modifier 59 is an important component of dermatology claims. Dermatology practices must stay up to date on the appropriate use of modifier 59 to avoid unwarranted claim denials and audits.

Modifier 59, Distinct Procedural Service, is used to identify procedures/services, other than evaluation and management services (E/M), that are not normally reported together, but are appropriate under the circumstances.

Appending modifier 59—or any modifier—to an add-on code is inappropriate, unless your payer specifically requests you do so.

- Documentation must indicate that the procedures involved different lesion sites, different sessions/patient encounters, or different procedures/surgeries performed on the same day by the same physician.
- Modifier 59 should not be used as a “bundle breaker” to bill for code pairs prohibited by NCCI edits for the same lesion.

MUEs
Medically unlikely edits (MUEs) were developed to reduce paid-claims error-rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a healthcare provider may report under most circumstances for a single beneficiary on a single DOS.

MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. These edits are based on:

- Anatomic considerations;
- HCPCS/CPT code descriptors;
- CPT instructions, CMS policies;
- Nature of service/procedure;
- Nature of analyte;
- Nature of equipment; and
- Clinical judgment

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Note: Not all HCPCS/CPT codes have an MUE.

For example, the following CPT code MUEs are listed as per date of service limitations:
fraud and abuse. National healthcare organizations and contractors with information about MUE values that are not published on the CMS website should continue to maintain confidentiality of those values. In addition, some codes having MUEs with lower values believed by CMS to be particularly vulnerable to fraud and abuse may not be published.

NCCI edits are utilized by Medicare claims-processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

As such, healthcare providers are discouraged from interpreting MUE values as usage guidelines. MUE values do not represent units of service that may be reported without thought or concern about medical review. Providers must continue to report only services that are medically reasonable and necessary.

Add-on Code Edits
Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is also reported and eligible for payment. That is, add-on codes cannot be reported without the appropriate primary procedure code on the same DOS. For example:

- Skin biopsy add-on codes
  - 11103 may be reported with either 11102, 11104 and 11106
  - 11105 may be reported with either 11104 or 11106
  - 11107 may be reported with 11106
- Removal of skin tags code 11201 must reported with 11200
- Debridement codes
  - 11045 must be reported with 11042
  - 11046 must be reported with 11043
  - 11047 must be reported with 11044
- Destruction of actinic keratosis code 17003 must be reported with 17000
- Mohs surgery codes 17312 must be reported with 17311 and code 17313 must be reported with 17312

Policy Manual Background
The NCCI Policy Manual for Medicare Services and NCCI edits were developed to apply to Medicare services billed by a single provider for a single patient on the same DOS. The edits were developed to encourage consistent and correct coding and reduce inappropriate payment, which do not include all possible combinations of correct coding edits or types of unbundling that exist.

Healthcare providers are required to code correctly even when edits do not exist to prevent the use of an inappropriate code combination(s). If a provider that the coding has been done incorrectly, they should contact their Medicare Administrative Contractor (MAC) about potential payment adjustments.

CPT codes that represent services that are denied based on the NCCI edits cannot be billed for Medicare beneficiaries. Because these denials are based on incorrect coding rather than medical necessity, the provider cannot use an advanced beneficiary notice” (ABN) form to seek payment from a Medicare beneficiary.

Because NCCI is a CMS program, its policies and edits represent CMS national policy. Nevertheless, NCCI policies and edits do not supersede other CMS national coding, coverage, or payment policies.

Sometimes, third-party payers may use the NCCI edits as they deem necessary. It is important for dermatology practices to check third-party payer contracts to determine if they follow NCCI policies to determine correct coding and claim processing.

The latest package of PTP CCI edits (version 25.1), which is effective on January 1, 2019, is now available through the CMS Data Center at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

For more information, visit:
- Overview and Background at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html.
Do Not End Up On the OIG Medicare List of Overpayment Recoveries Statistics

The following statistics may peak your interest.

From Oct. 1, 2014 to Dec. 31, 2016, the Office of Inspector General (OIG) issued 153 audit reports related to the Centers of Medicare & Medicaid Services (CMS) program. The report contained 193 monetary recommendations totaling $648 million. Of the $648 million in recommended overpayment recoveries, CMS agreed to collect $566 million applicable to 190 recommendations.

The Department of Health and Human Services (HHS) is responsible for resolving federal audit-report recommendations related to its activities, grantees, and contractors within six months after formal receipt of the audit report.

Effects On Dermatology Practice

When your dermatology practice’s claim submissions are not supported by medical record documentation or when services are overbilled (reporting a higher service than what was performed), your practice may be included in the statistics above.

As part of the 2019 OIG Work Plan, the following recommendations were submitted to HHS/CMS:

The extent to which CMS:

✓ collected agreed upon Medicare overpayments identified in OIG audit reports; and
✓ took corrective action in response to the recommendations in the OIG prior audit report examining CMS’ overpayment recoveries.

• In that report, the OIG recommended that “CMS enhances its systems and procedures for recording, collecting, and reporting overpayments, as well as providing guidance to its contractors on how to document that overpayments were actually collected.”

Role of CMS Beyond the OIG Work Plan

CMS also performs many program-integrity activities to reduce fraud, waste, and abuse that are beyond the scope of the OIG Work Plan. These include, but are not limited to:

✓ Medicare fee-for-service (MFFS) and Medicaid improper payment-rate measurement;
✓ Medicaid program-integrity activities;
✓ Fraud prevention system (FPS); and
✓ Recovery audit contractor (RAC) activities.

CMS and Fraud Prevention System (FPS)

CMS uses a multifaceted approach to target all causes of fraud, waste, and abuse that result in improper payments, with an emphasis on prevention activities. It focuses on initiatives that are fundamental in addressing program integrity across the gamut, while improving payment accuracy. CMS has invested considerable resources in systems and initiatives related to data and analytics to prevent or rapidly identify fraud, waste, and abuse.

The FPS analytics technology used by CMS since 2011, runs predictive algorithms on all MFFS claims. The analytics are run continuously prior to payment to identify, prevent, and stop potentially fraudulent claims. The system helps CMS target potentially fraudulent providers and suppliers, while reducing the administrative and compliance burden on legitimate providers and suppliers.

In 2016, the FPS helped CMS identify or prevent $527.1 million in inappropriate payments, which resulted in a $6.30 to $1.00 return on investment (ROI). Since CMS implemented the original FPS technology in June 2011, the FPS has identified or prevented almost $2.0 billion in inappropriate payments by discovering new leads or contributing to existing investigations. Out of the FPS models generated in 2016, 688 of all leads were included in the zone integrity program (ZPIC).

NCCI Role

Given the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, CMS uses automated edits to help prevent improper payment without the need for manual intervention. As previously stated, the national correct coding initiative (NCCI) program consists of edits designed to reduce improper payments in Medicare Part B. CMS originally implemented the NCCI program in the Medicare program in January 1996 using procedure-to-procedure (PTP) edits to ensure accurate coding and reporting of services by physicians.

The PTP edits prevent inappropriate payment for billing code-pairs that should not be reported together by the same provider for the same beneficiary on the same date-of-service (DOS). In addition to PTP edits, CMS established the medically unlikely edit (MUE) program in 2007 as part of the NCCI program to reduce the Medicare Part B paid-claims improper payment rate. MUEs prevent payment for an inappropriate number/quantity of the same service on a single day.

— see OIG on page 7
Since October 2008, CMS has publicly posted all PTP edits and a majority of MUEs on the CMS website at https://www.cms.gov/Medicare/Coding/National-CorrectCodInitEd/index.html. To prevent misuse or manipulation by fraudulent or abusive individuals and entities, CMS does not publish certain edits. The use of PTP and MUE edits saved the Medicare program $186.9 million and $359.8 million respectively during the first nine months of FY2017.

IDR and One PI Portal
How does CMS know if your claim submission history is flawed? By using the Integrated Data Repository (IDR) and One Program Integrity (One PI) portals. CMS has continued to enhance the data available in the IDR so it can provide a comprehensive view of Medicare and Medicaid data that include claims, beneficiary data, and prescription drug information.

By using the IDR to provide broader and easier access to data, the enhanced data integration strengthens and supports CMS’ analytical capabilities. The IDR contains paid claims for Medicare Part A, Part B (including DME), Part C (encounter), and Part D from as far back as January 2006, both before and after final payment.

In addition, CMS has added shared systems location data for pre-adjudicated claims, claims submitter, and medical review utilization data. CMS then uses the One PI web-based portal in conjunction with the IDR to facilitate data sharing with program-integrity contractors and law enforcement. The portal provides a single-access point to the data within the IDR, as well as the analytic tools to review the data.

CMS has also created a command center, which provides an opportunity for Medicare and Medicaid policy experts, law enforcements officials from HHS-OIG and the DOJ, including the Federal Bureau of Investigation (FBI), state law enforcement officials, clinicians, and CMS fraud investigators, to collaborate before, during, and after the development of fraud leads in real time. The command center has advanced technologies and a collaborative environment that allows multidisciplinary teams of experts and decision makers to efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action.

These collaborative activities enable CMS to take administrative actions, such as revocations of Medicare billing privileges and payment suspensions, more quickly and efficiently. In FY 2017, 25 missions were conducted in the command center, which included participants from CMS, CMS partners, and even the FBI.

Do Not Be A Statistic In Medicare-Claims Review
One of CMS’ goals is to conduct provider outreach and education to reduce Medicare and Medicaid improper payment rates by giving participating providers timely and accurate information needed to bill correctly, the first time around.

Medicare administrative contractors (MACs) educate participating providers and their staff about Medicare policies and procedures, including local coverage policies, significant changes to the Medicare program, and issues identified through review of provider inquiries, claim-submission errors, medical-review data, and comprehensive error rate testing (CERT) program data.

MACs use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program, including CMS-developed materials and contractor-developed materials.

It is important for dermatology practices to pay close attention and understand coding changes and local and national coverage determinations (LCDs/NCDs) policy updates that are published by CMS.

As the OIG continues HHS oversight with increased pressure to reduce fraud, waste, and abuse, being up to date with these resources will prevent your practice from making coding errors that will result in claim denials, payer audits, and your practice becoming part of the erroneous claim-payment statistics discussed above.

For more information, visit https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf for the HHS and DOJ’s T Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2017.
FAQs

Q1. When reporting additional biopsies beyond the MUE limit, how should charges be submitted?

A1. Services that exceed the MUE limit can be submitted in the same manner by which regular claims (those within MUE limits) are submitted. The difference between the two submission will be that the units beyond the MUE limits will usually be denied and a redetermination with medical records to justify the medical necessity will be submitted for consideration.

For example:

Four incisional biopsies reported as 11106; 11107 x2; 11107-76

Note: Incisional biopsy, additional lesion CPT code 11107 has a date of service MUE of 2; the use of modifier 76 will not circumvent the claim-edit denial.

In this case, the third unit will have to be appealed with medical records to support the medical necessity for the extra biopsy performed.

Therefore, be prepared to appeal for the additional units of the MUE

Q2. Patient presents with a biopsy proven basal cell carcinoma (BCC). Physician uses a punch instrument to excise the lesion. Should this be coded as an excision (code 116XX) or punch biopsy (code 11104)?

A2. It is important to note that the new skin biopsy codes are selected and reported based on the intent of the procedure. In order to report the skin biopsy code, the provider has to indicate that:

✓ The intent of the procedure was solely to obtain tissue for diagnostic histopathologic examination; and

✓ The procedure was performed independently or was unrelated and distinct from other procedures/services provided during the same encounter.

Note that malignant lesion excision is defined as full-thickness (through the dermis) removal of a lesion including margins.

In the example above, the documentation indicates that a previous skin biopsy was performed at the time the BCC was diagnosed, and the patient has now returned to have the entire lesion removed. As such, it is important to report the malignant lesion excision code 11600.

Q3. Do the new skin biopsy codes still have 0-day global period?

A3. Yes, the new codes still hold a 0-day global period.

Q4. If two skin biopsies are performed, one of the lip and the other a tangential biopsy of the cheek, is the skin biopsy reported in addition to the site-specific biopsy?

A4. Correct, the biopsy of lip (code 40490) is reported in addition to the tangential biopsy (code 11102) with modifier 59 appended to the tangential biopsy code: 40490 and 11102-59.

In the Know...

CMS Announces Updates to Medicare Program Integrity Manual: Outlines Detailed Changes to the LCD Process

Did you know that in response to comments through meetings and correspondence with stakeholders (providers and healthcare associations) and the CY2018 Medicare Physician Fee Schedule (MPFS) proposed rule (82 FR 33950) released in July 2018, Medicare has now released updates to the local coverage determination (LCD) process?

Most stakeholders have acknowledged and indicated to Medicare that the local coverage process is an important means to provide decisions related to the items and services that benefit Medicare beneficiaries. These decisions ensure beneficiary access to life saving and medically necessary products and procedures. However, there has been concern about the lack of local coverage process transparency, including stakeholders’ notification of proposed revisions to, drafting of, and release of new LCDs.

Other stakeholder concerns include ineffective MAC processes for soliciting from, providing feedback on information provided during open public meetings, a lack of nonphysician representation on contractor advisory committees (CACs), and concerns that CAC meetings are not open to the public.

In response to the new statutory (21st Century Cures Act of 2016) requirements and the stake-
New CPT® Skin Biopsy and ICD-10-CM Code Changes for 2019 are here

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holder comments, CMS through Change Request (CR) 10901, has announced updated instructions to MACs that reflect policy-process changes to the LCD process in the revised Chapter 13 of the Medicare Program Integrity Manual (Manual).

The 21st Century Cures Act of 2016 included changes to the LCD process by adding language to §1862(l)(5)(D) of the Social Security Act (the Act) that now describes the LCD process. Section 1862(l)(5)(D) of the Act requires each MAC that develops an LCD to, in no less than 45 days before the effective date of determination, make available the following information on their website:

- The determination in its entirety
- Where and when the proposed determination was first made public
- Hyperlinks to the proposed determination and a response to comments submitted to the MAC with respect to the proposed determination
- A summary of evidence that was considered by the contractor during the development of the determination with a list of evidence sources
- An explanation of the rationale that supports the determination

CMS indicates that the revamping of the Manual’s format could be used as a roadmap to understand the steps of the LCD process, which enable stakeholders to effectively engage in the evolution of the method. This transparency carries through to the reconsideration process, the step that stakeholders can take to request that a MAC take a second look at an existing decision using evidence that has been developed since its first review.

The Manual also sets consistent requirements for communication to providers and other stakeholders to occur at predictable milestones so anyone with an interest in the local determination can stay informed as it moves through the process.

New LCD Process
The following are key parts of the new LCD process:

1. Process may begin with informal meetings in which interested parties within the MAC’s jurisdiction can discuss potential LCD requests. These educational meetings, which are not required, can be held either in person, using web-based technologies, or via teleconference that allow discussions before requestors submit a formal request.

2. New LCD Requests
The new LCD request process is a mechanism through which interested parties within a MAC’s jurisdiction can request a new LCD. In this process, MACs will consider all new LCD requests from:

- Beneficiaries residing or receiving care in the MAC’s jurisdiction
- Healthcare professionals doing business in the MAC’s jurisdiction
- Any interested party doing business in the MAC’s jurisdiction

MACs will consider a new LCD request to be complete and formal, if the following requirements are met:

- Request is in writing and sent to the MAC via e-mail, facsimile, or written letter.
- Request clearly identifies the statutorily-defined Medicare benefit category to which the requestor believes the item or service applies.
- Request identifies the language that the requestor wants in an LCD.
- Request includes a justification supported by peer-reviewed evidence (full copies of published evidence must be included or the request is not valid.
- Request addresses relevance, usefulness, clinical-health outcomes, or the medical benefits of the item or service.
- Request fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

The MACs will in turn review the materials and determine whether the request is complete or incomplete within 60 calendar days from the day they received the request. If it is deemed complete, the MAC will follow the new LCD process, as described in the updated Manual. However, if the process is deemed incomplete, they will respond in writing to the requestor explaining why it was incomplete.

3. Clinical Guidelines, Consensus Documents, and Consultation
During the development of an LCD, MACs should (when applicable and available) supplement their research with clinical guidelines, consensus documents, or consultation by experts (recognized authorities in the field), medical associations or other healthcare professionals for an advisory opinion. They will summarize the opinions they receive as a result of this consultation prior to the drafting of a proposed or final LCD and will include this information in the proposed or final LCD.

Note: Acceptance by individual healthcare providers, or even a limited group of healthcare
providers, does not indicate general acceptance of the item or service by the medical community.

4. Publication of the Proposed LCD
The public announcement of a MAC’s proposed determination begins with the date the proposed LCD is published on the Medicare coverage database (MCD) at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Once the proposed LCD is published, MACs provide a minimum of 45-calendar days for public comment, and will contact CMS if an extension to the comment period is needed.

**Note:** These processes shall be used for all LCDs except for specific situations listed in CR 10901.

5. CAC
The contractor advisory committee (CAC) will be composed of healthcare professionals, beneficiary representatives, and representatives of medical organizations, and it is used to supplement the MAC’s internal expertise and to ensure an unbiased and contemporary consideration of “state of the art” technology and science.

In addition, all CAC meetings will be open to the public to attend and observe. MACs will establish one CAC per state or one per jurisdiction with representation from each state, ensuring that each state has a full committee and the opportunity to discuss the quality of evidence used to make the determination. The CAC is advisory in nature, with the final decision on all issues resting with MACs.

6. Open Meeting
After the proposed LCD is made public, MACs will:

- Notify the public about the dates and location for the open meeting.
- Hold open meetings to discuss the evidence review and the rationale for the proposed LCD(s) with stakeholders in their jurisdiction.
- Members of the CAC may also attend these open meetings.

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**In the Know...**

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**CMS**

*The CAC’s purpose is to provide a formal mechanism for healthcare professionals to be informed of the evidence used in developing the LCD and promote communications between the MACs and the healthcare community*

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✓ Have the option of setting up email listservs to announce this information or may use other education methods to adequately inform the public.

• The listserv or other posting should clearly identify the location, dates, and telephone/video/online conference information for the open meetings to clearly distinguish them from the CAC meetings.

Interested parties (generally those who will be affected by the LCD, including providers, physicians, vendors, manufacturers, beneficiaries, caregivers, etc.) can make presentations of information related to the proposed LCDs.

7. **Publication of the Final Determination**

After the close of the comment period and the required meetings and consultation, the final LCD and the response to comment (RTC) article will be published on the MCD. MACs will respond to all comments received during the comment period of the proposed LCD by using the RTC article associated with the LCD.


Questions about this change request should be directed to your regional MAC. MAC websites are located at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

Now You Are In The Know! ✨