The Role of Medicare Administrative Contractors and Updates to Coding Policy

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Medicare Administrative Contractors (MACs) act on behalf of the Centers for Medicare & Medicaid Services (CMS) as a direct point of contact for claims submission and payment, policy establishment, and special pricing of services. Other services by MACs, per CMS, include enrollment of providers under Medicare's fee-for-service program, responses to provider inquiries, and education about Medicare fee-for-service billing requirements. MACs replaced Medicare Fiscal Intermediaries and Carriers, so that MACs are now a central point of contact. (Historically, Fiscal Intermediaries covered those paid under the Hospital Outpatient Prospective Payment System and Carriers covered those paid under the Medicare Physician Fee Schedule).

MACs cover assigned designated jurisdictions, which are split by CMS to encompass the United States and its territories. MAC contracts are awarded through an application process once every 10 years. As part of the Medicare Access and CHIP Reauthorization Act enacted on April 16, 2015, contract terms were extended from the previous 5-year agreement to 10 years. It is possible for a jurisdiction to be awarded to a different contractor as part of the rebidding process, and MACs may be awarded more than one jurisdiction. Some of the recent changes made in September 2017 include the states of Alabama, Georgia, and Tennessee, which were awarded to Palmetto GBA after Cahaba GBA, LLC, lost the rebid. In September 2019, Wisconsin Physician Services was again awarded Jurisdiction 5, and the contract for Jurisdiction E (currently run by Noridian Healthcare Solutions) is up for rebid, which should be announced by October 2020. Table 1, page 8, identifies the current MAC awards for each jurisdiction along with the covered states and links to the home page of each MAC.

MACs are responsible for creating and maintaining Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs). LCDs and LCAs contain information, such as what diagnoses are considered medically necessary, specific documentation requirements for a given modality, and how to bill for services. Since October 2018, LCDs have undergone process and content changes for all MACs. Some changes include more transparency to the process, as well as public and stakeholder input—providers can participate in discussions about and submit requests for new ideas and revisions to LCDs. Additionally, the LCD itself will now only have initial information related to the modality or service, whereas the LCAs attached to the LCD contain the billing and coding guidelines, as well as codes covered in the *International Classification of Diseases*, 10th revision. Not all MACs will have LCDs or LCAs related to oncology services, but there are several that do or have created resources on their websites. It is important to sign up for email alerts from your respective MAC to ensure receipt of alerts regarding coverage and coding changes, including opportunities for educational webinars and resources for providers.

Over the last several years, many of the MACs have implemented changes that may only pertain to their jurisdiction. Therefore, it is important to remember that when discussing scenarios with other providers, the context and application of coding guidelines may not apply to everyone. The following are some examples of recent MAC updates that are impactful to oncology services and may not apply to everyone nationwide but are important to be aware of.

Local Coverage Article A56141

In a recent update impacting medical oncology providers, Palmetto GBA (Jurisdictions J and M) revised their LCA: "Billing and Coding: Chemotherapy (A56141)," effective April 30, 2020. Palmetto GBA is now requiring the use of **modifier KX** for the drugs listed in the policy that are used off label, along with additional coding edits. In addition, several of the drugs outlined in LCA A56141 require medical record documentation to support certain drug combinations, other failed therapies, previous drugs, etc. It is important to note that other MACs do not have the same billing requirements as part of their LCDs or LCAs.

LCA A56141 went into effect November 1, 2018, and Palmetto GBA indicated that it feels that this is an appropriate time for providers to comply with the coverage requirements listed in the article. Therefore, Palmetto GBA is implementing diagnosis edits for HCPCS codes and will continue to provide notification on effective dates of any edits implemented. All coverage require-

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Table 1. Medicare Administrative Contractors Awarded as of September 2019

JURISDICTION	MAC	WEBSITE	STATES COVERED
J15	Celerian Group Company (CGS)	cgsmedicare.com	Kentucky, Ohio
JN	First Coast Service Options	medicare.fcso.com	Florida, Puerto Rico, Virgin Islands
J6	National Government Services (NGS)	ngsmedicare.com	Illinois, Minnesota, Wisconsin
JK	National Government Services (NGS)	ngsmedicare.com	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
JE	Noridian Healthcare Solutions	noridianmedicare.com	American Samoa, California, Guam, Hawaii, Nevada, Northern Marianas Islands
JF	Noridian Healthcare Solutions	noridianmedicare.com	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
JH	Novitas Solutions	novitas-solutions.com	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
JL	Novitas Solutions	novitas-solutions.com	Delaware, Washington, D.C., Maryland, New Jersey, Pennsylvania, Virginia (counties of Arlington, Fairfax; City of Alexandria)
JJ	Palmetto GBA	palmettogba.com	Alabama, Georgia, Tennessee
JM	Palmetto GBA	palmettogba.com	North Carolina, South Carolina, Virginia (except areas noted as Novitas), West Virginia
J5	Wisconsin Physician Services (WPS)	wpsgha.com	Indiana, Iowa, Kansas, Nebraska
J8	Wisconsin Physician Services (WPS)	wpsgha.com	Michigan, Missouri

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ments in the coverage article continue to remain in effect. In the email notification by Palmetto GBA about the updates to LCA A56141 it stated, "Providers should pay specific attention to the coverage article as it relates to billing off label use and the HCPCS **modifier KX** for any drug or biological outlined in the article."

The following language is located within LCA A56141, specifically about **modifier KX**.

"Palmetto GBA expects that providers identify off-label uses by the use of the 'KX' modifier appended to the CPT/HCPCS code for the drug. These off-label uses must be supported by clinical research under the conditions identified in this section. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication. In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration. Such usages will be subject to review at the discretion of Palmetto GBA. For review of medications under these considerations, please submit full articles, not abstracts, for consideration."

LCA A56141 can be found by visiting the Palmetto GBA website and selecting the respective jurisdiction and medical policies, palmettogba.com.

Radiation Oncology-Specific LCDs and Coverage Articles

A few MACs have radiation oncology-specific LCDs and LCAs related to intensity-modulated radiation therapy and stereotactic radiotherapy services—stereotactic radiosurgery (SRS) and stereotactic body radiotherapy. However, over the last several years, many MACs have retired LCDs specific to radiation oncology services. When a MAC retires an LCD, the LCD is still applicable for billing and coding guidelines, audits, medical necessity, and Advanced Beneficiary Notices. For example, Novitas Solutions indicates in its retired LCD Radiation Therapy Services (L27515) that only one immobilization device can be billed per volume of interest. If a head and neck patient had a mask, bite block, and custom head cushion, only one device is billable for any provider under Novitas Solutions. The rest of the MACs do not have this same limitation; for those outside of the Novitas Solutions jurisdictions, three different immobilization devices could be billed.

In other radiation oncology LCDs, MACs have various statements about the necessary participation of the radiation oncologist and neurosurgeon when providing stereotactic radiotherapy services. Currently, Noridian Healthcare Solutions states within LCA A57461, "No one physician may bill both the neurosurgical codes 61781-83, 61796-61800, 63620 or 63621 and the radiation oncology 77xxx codes. The physician(s) billing these codes must be physically present during the entire process of defining the target volume and structures at risk. If either the radiation oncologist or the neurosurgeon does not fully participate in the patient's care, that physician must take care to indicate this change by using the appropriate -54 modifier (followed by any appropriate -55 modifier) on the global procedure(s) submitted. As the services are collegial in nature with different specialties providing individual components of the treatment, surgical assistants will not be reimbursed."

First Coast Service Options also addresses the available codes for radiation oncologists and neurosurgeons in LCA A57275 but does not state that the neurosurgeon must be physically present for the entire process. First Coast Service Options states, "Usually, a radiation oncologist will work with a neurosurgeon to perform SRS. Radiation oncologists and neurosurgeons have separate CPT codes for SRS. CPT codes 61796-61800 are reported for the work attributed to the neurosurgeon. These codes are mutually exclusive with the radiation oncology CPT codes 77432 and 77435; therefore, the same physician should not bill for both these codes."

Lastly, National Government Services also has an LCA for stereotactic radiotherapy, but it does not address the billing codes or participation by any of the providers within the LCD or LCA.

Due to the variances in policy by MACs and the potential for updates to policies throughout the year, it is important that providers are familiar with their MAC and how to access its information. The LCDs and LCAs can be used as educational tools with staff and providers to understand the expectations of the payer, coverage limitations, and documentation requirements. In addition, in the absence of other payer policy or in discussions with private payers, they may aid in supporting departmental processes to align with Medicare expectations. OI

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