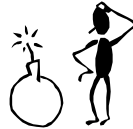
Medicare Local Medical Review Policies
Tool Kit

Frustrated? Trying to understand the ins and outs of Medicare coverage for psychological services?

Confused? Baffled?

 Wondering where Medicare coverage provisions could possibly have come from?

Good News!!!

Here's help for psychologists interested in understanding Medicare provisions and providing input into their development!

American Psychological Association
Committee on Aging & Office on Aging
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Introduction

The APA Committee on Aging (CONA) is often contacted by psychologists attempting to provide the best possible care for older adults and others, whose primary health insurance is Medicare. They express frustration in trying to understand the ins and outs of Medicare coverage for psychological and behavioral health services. They are baffled by the origin and rationale of Medicare coverage provisions and their geographic variability. For example, would the following provision concern you: “Psychotherapy is an effective adjunctive form of treatment for new psychiatric conditions, while other psychiatric illnesses primarily require treatment with medications.”?

Recent changes in Medicare policies and procedures mandated by the Centers for Medicaid and Medicare Services (CMS), formerly the Health Care Financing Administration (HCFA), attempt to make the policy development process clearer and more accessible to Medicare providers.

These changes also create opportunities for concerned psychologists to provide input into the development of local medical review policies (LMRP) that determine coverage for services under Medicare. **The importance of this opportunity cannot be overstated**. It is a critical step in assuring the availability of appropriate and needed services for older adults and other Medicare beneficiaries.

In order to become involved, it is important for psychologists:

- to educate themselves about local policies and procedures
- to link with other like minded psychologists and organizations such as state-level psychological associations [link to SPAs]
- to gain access to the process resulting in important policy decisions
- to provide sensible, evidence-based input into decisions that dramatically affect patients’ access to necessary care.

This LMRP Tool kit provides the information and necessary tools to make a difference. It is our hope that it enables more psychologists to become involved in the development of these policies that profoundly impact the availability of psychological and behavioral services for older Americans.

APA Committee on Aging (CONA)
2003

Acknowledgements

CONA would like to thank Leslie Fried, JD of the American Bar Association/ Alzheimer’s Association Medicare Advocacy Project for bringing the LMRP issue to the forefront of their advocacy agenda. We applaud the Project’s commitment to this issue and Ms. Fried’s guidance in outlining critical components of this tool kit.

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CONA would also like to thank the Psychologists In Long Term Care organization for allowing us to include a sample of their correspondence in Part III of the tool kit.

Finally, CONA would like to acknowledge Susan Hurt, JD, PhD for her work as consultant to the APA Office on Aging and LMRP Project. Dr. Hurt's review and analysis of LMRPs nationwide and her role in the development of this tool kit are to be commended.

Goal/Content/Limitations of Toolkit

The goal of this tool kit is to help practicing psychologists provide important input into Medicare coverage for psychological services. Its focus is on Medicare Part B, Supplementary Medical Insurance. It provides basic information and tools to support your efforts to become involved in the development and revision of Local Medical Review Policies that determine coverage for psychological services under Medicare.

The tool kit contents are divided into three parts. **Part I: LMRP Basics**, provides a working knowledge of Medicare Local Medical Review Policies – definitions, typical policy provisions for psychological services and the primary parties. **Part II: Opportunities for Involvement**, suggests what you can do to become involved and describes the Process for LMRP development and revision, noting opportunities for psychologists to become involved in this policy development process. A *Monitor on Psychology* article highlighting the efforts of psychologists in NY to revise their LMRP is also included. **Part III** provides the tools to facilitate psychologist involvement in the LMRP process. Included are: examples of problematic language often appearing in draft LMRPs and revised language that more accurately reflects psychological research and practice; examples of recent positive changes in policy language; sample correspondence to the local insurance carrier; and, references for empirical studies which support the efficacy of a variety of psychological services.

There are two **limitations** of the Toolkit related to its scope. The Toolkit focuses on LMRPs and their development process. However, an LMRP is one part of a multi-layered set of policies and guidelines that control Medicare claims. The Center for Medicaid and Medicare Services (CMS), a division within the Department of Health and Human Services, has responsibility for administering the Medicare program. In turn, CMS contracts with various health care insurance agencies to manage the program locally.

This system of delegated responsibility, from Congress, to CMS, to private carriers, has resulted in a hierarchy of policies, rulings, and guidelines that control Medicare claims. For those interested in a more in-depth understanding of this hierarchy of laws, policies

and guidelines that control Medicare claims [click here]. [Note: the reader will be directed to a page that says: "For those interested in a more in-depth understanding of this hierarchy of laws, policies and guidelines that control Medicare claims, there are two sources of information. To learn more about coverage provisions under Medicare, see the Code of Federal Regulations, Title 42, Public Health, Chapter IV at: http://lula.law.cornell.edu/cfr/index.php. For a comprehensive database including the multiple sources of coverage provisions and controlling determinations, see newly created The Medicare Coverage Database http://cms.hhs.gov/coverage. It includes National Coverage Determinations, National Coverage Analyses and LMRPs.

For those interested in more general questions about Medicare, such as how to become a Medicare provider, see the APA Practice Directorate's Medicare Handbook http://www.apa.org/practice/medtoc.html.

Part I: LMRP Basics

Definition of an LMRP

An LMRP is a Local Medical Review Policy. LMRPs are the coverage policies that are developed by the Medicare Insurance Carriers and apply directly to claims made to the Insurance Carrier for Coverage under Medicare. LMRPs outline how local carriers will review claims to ensure that they meet Medicare coverage and coding requirements. They specify under what clinical circumstances a service is covered and correctly coded. An LMRP includes a description of the service, specific procedure codes, and for each of these procedures, a list of covered and non-covered diagnostic codes.

LMRPs are issued separately for types of medical services, including Psychiatry and Psychological Services, so hundreds of LMRPs are in existence for each local carrier. In general, carriers have wide freedom to determine coverage; the only restriction is that their policies not directly conflict with a National Coverage Decision issued by CMS on the same issue.

LMRPs have been defined by CMS as "an administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment" within a specified geographic area. However, the major goal of these local policies is to prevent overutilization of clinical services paid by CMS. Their impact on providers and beneficiaries can be to limit coverage or to deny claims outright. To view existing LMRPs on-line, including those for Psychiatric and Psychological Services, go to www.lmrp.net. This site will direct you to the websites of Medicare carriers by state.

Overview of Coverage for Psychological Services

This section provides a brief overview of common coverage provisions for psychological services under several LMRPs across different states. Its purpose is to acquaint the reader with the general nature of provisions as they commonly appear including provisions specific to dementia. **Language presented in this section may or may not be similar to the coverage provisions that apply in your locality. For specific information about current coverage provisions where you practice, find the policy that applies at www.lmrp.net.**

The most common LMRP for coverage for psychiatry and psychology services under Medicare Part B divides coverage into six sections, five of which are relevant to psychologists (Section 4, pertaining to medication management is reserved at this time for billing by physicians). The five sections of coverage relevant to clinical psychologists are:

1. General Clinical Psychiatric Diagnostic or Evaluative Procedures
2. Special Clinical Psychiatric Diagnostic or Evaluative Procedures
3. Psychiatric Therapeutic Services
5. Other Psychiatric Therapy
6. Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)

Section 1: General Clinical Psychiatric Diagnostic or Evaluative Procedures provides for a complete diagnostic evaluation. The CPT code* associated with Section 1 (90801) does not distinguish billing between physicians or psychologists. [* Current Procedural Terminology @2003 American Medical Association. All Rights Reserved]

Section 2: Special Clinical Psychiatric Diagnostic or Evaluative Procedures provides for diagnostic evaluation of patients who are not able to interact with ordinary verbal communication. Although the section is primarily intended for diagnostic evaluations of children, it may also be applied to patients with organic mental deficits or who are catatonic or mute. This section contains a specific exclusion for the dementias, however, as follows:

> Other catatonic states may be covered if documentation is submitted with the claim. Coverage also includes interactive examinations of patients with primary psychiatric diagnoses (e.g., Axis I DSM IV diagnoses), excluding the dementias (ICD-9-CM codes 290.0-290.9) and sleep disorders and one of the following conditions [neurotic disorders, personality disorders and other nonpsychotic mental disorders, diseases of the ear and mastoid process, or symptoms involving the head or neck].

Section 3: Psychiatric Therapeutic Services is the primary coverage section for psychotherapy services, including individual, group, and family psychotherapy. The codes covered by this section are divided by whether Evaluation and Management services are included (billable only by physicians), by treatment setting, by length of session, and for family therapy, by whether the patient is present. Coverage is not

included for teaching grooming skills, monitoring activities of daily living, or recreational therapy.

For Medicare coverage, the focus of family therapy must be the treatment of the patient's condition. Examples of covered purposes include observing and correcting the patient's interaction with family members and assisting family members in the management of the patient. Family therapy is generally not covered if directed to the effects of the patient's condition on the family. Similarly to individual psychotherapy, group therapy is not covered if its purpose is socialization, recreational activities, art, music, excursions, or cognitive or sensory stimulation.

For some states, psychoanalysis is specifically addressed in Section 3; coverage is limited to trained practitioners and to a small range of disorders, emphasizing depression, anxiety, panic, hysteria, and phobias.

The following limitation applies to all types of therapy provided for in Section 3:

> Psychotherapy services are not covered when documentation indicates that Dementia (ICD-9 codes 290.0, 290.20-290.9, 331.0-331.2) has produced a severe enough cognitive defect to prevent psychotherapy to be effective. . . In such cases, rehabilitative, evaluation and management (E/M) codes or pharmacologic management codes should be reported.

The language of this exclusion varies slightly between policies, with some policies emphasizing that the cognitive deficit prevents establishment of a relationship with the therapist. Policies also differ in whether they list ICD codes 331.0-331.2 (Alzheimer's Disease, Pick's Disease, and Senile Degeneration of Brain) in the limitation.

Section 4: Psychiatric Somatotherapy pertains to medication management and is reserved at this time for billing by physicians.

Section 5: Other Psychiatric Therapy provides limited coverage for other modes of psychotherapy, such as biofeedback and hypnosis. Biofeedback is not covered for mental illness under Medicare, and hypnotherapy is covered for a limited range of disorders (conversion disorders, psychogenic amnesia, psychogenic fugue, multiple personality, dissociative disorder or reaction, phobias, stress disorders, psychogenic pain).

Section 6: Central Nervous System Assessments/Tests provides coverage for psychological and neuropsychological testing. A typical description of psychological testing states that "Code 96100* includes the administration, interpretation and scoring of the tests mentioned in the CPT description and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis." Limitations to coverage are rooted in the concept of medical necessity; most policies state that the following situations would not give rise to medically necessary psychological testing: screening when mental illness is not suspected; standardized batteries of tests; repeat testing not required for change in diagnosis or treatment; examinations that can be

completed through interview alone; and adjustment reactions to being moved to a nursing facility. [* Current Procedural Terminology @2003 American Medical Association. All Rights Reserved]

A typical description of neuropsychological testing states that "Code 96117* describes testing that is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain." Covered purposes of testing include detection of neurologic disease; differential diagnosis between psychogenic and neurogenic syndromes; delineation of the neurocognitive effects of central nervous system disorders; monitoring of recovery of progression of central nervous system disorders; and formulation of rehabilitation or management strategies. [* Current Procedural Terminology @2003 American Medical Association. All Rights Reserved]

The Primary Parties in LMRP Development

The primary parties in LMRP development are the Contract Medical Director (CMD) and the Carrier Advisory Committee (CAC) of each insurance contractor. The CMD has primary responsibility for developing the LMRP and submitting it to the CAC. The CAC is a committee established by the contractor and the primary forum for development and discussion of proposed LMRPs.

Prior to January 2001, in most cases, the CMD and the CAC developed LMRPs with limited review by CMS and none or little provider and public input. However at that time, a program memorandum was issued instructing contractors "to establish an open and public process for the development of LMRPs … providing more notice and opportunity for providers, physicians, suppliers and other interested parties to have input into the policies." Part III of this toolkit provides the tools you need will to have input into the process.

Carrier Medical Director (CMD) Facts:

- The CMD is a physician.
- The CMD is employed by the insurance carrier.
- CMD employment practices vary by state and carrier (e.g., whether they work full-time or part-time), so that it is necessary to get specific information about your CMD locally.

Carrier Advisory Committee (CAC) Facts:

- Contractors must establish one CAC per state. Where more than one carrier exists in a state, they must jointly establish that state's CAC.
- The CAC must meet at least 3 times per year, with no more than 4 months between meetings.

- CAC members voluntarily provide this service to their colleagues and profession; they are not compensated for their time or efforts.

- Members are selected from names recommended to the carrier by the State medical societies and specialty societies.

- Members must include physicians, a beneficiary representative and other medical organizations (such as State Hospital Associations or Medical Group Management Association). Additional members may attend meetings when policies that require their expertise are under discussion.

- Currently, representatives come from most clinical medical specialties. At the present time, Psychologists are not allowed to be members of CACs. Representatives of "medical" organizations are limited to those representing physician groups.

- The CAC is charged with providing a forum for input from physicians and other health care specialists in the state.

- The CAC disseminates proposed LMRP's to colleagues and specialty societies to solicit comments.

- The CAC disseminates information about the Medicare program obtained at CAC meetings to their respective State and specialty societies.

- The CAC discusses inconsistent or conflicting policies.

Part II: Opportunities for Involvement

What YOU can do to get involved

1. Although individual psychologists can raise the awareness of the local carrier in areas of import to psychology, the CAC process has built-in respect for efforts and presentations by professional societies, so that it may be a good idea for the initial and ongoing communications to demonstrate support of an organized group.

2. Find out what activities are already underway at your State psychological association. Is there already a committee in place addressing Medicare or insurance issues?

3. Work with a local committee, or establish a Medicare Committee of like-minded providers of psychological services to:

a. Systematically review draft policies on the LMRP website (www.draftlmrp.net) to track proposed changes to policy provisions regarding psychological services
b. Contact your local CMD and make your presence known
c. Take advantage of all open meetings for comments on draft LMRP language
d. Submit written comments via letter or e-mail on draft LMRPs
e. Organize with other interested providers to request changes to undesirable policy language in existing LMRPs
f. Offer your services or that of your committee to receive and review all policy changes regarding psychological services for the purpose of offering helpful input
g. Request an invitation to CAC meetings when policy provisions regarding psychological services are on the agenda.

4. Read on to learn more about the Process for LMRP development and revision, and corresponding points of opportunity for involvement.

Top 10 Reasons You Should Get to Know Your Carrier Medical Director (CMD) NOW:

10. CMS has recently promulgated notice and comment periods for all new and revised LMRPs, giving health care practitioners and their representative societies better access to the LMRP process.

9. CMS has recently required that all LMRPs be reviewed annually, increasing opportunities for input from interested parties.

8. CMS has recently clarified national policy on coverage for dementia, prohibiting local carriers from automatically denying claims.

7. CMS has recently provided that carriers must consider all LMRP reconsideration requests from providers doing business in a carrier's jurisdiction.

6. Psychologists are not currently included as required representatives on CAC's, so that additional contacts are necessary to remain visible in the LMRP development process.

5. CMDs are physicians representing numerous medical fields and may or may not be informed about the unique contributions of psychologists to beneficiaries' mental health.

4. The CMD is required to consider scientific evidence presented by psychologists.

3. The strength of the scientific basis for state-of-the-art psychological services should be made known to parties responsible for important decisions about patients' access to services.

2. Psychologists in New York developed relationships with their CMD over several years before effecting beneficial policy changes.

1. The CMD is primarily responsible for developing new LMRP language.

How to find your local CMD and CAC

Carrier Medical Directors are listed by name in the Carrier Directory section of the main LMRP website (www.lmrp.net; Directory; Part B). This should be a good starting point for contact information and meeting dates for your local Carrier Advisory Committee.

LMRP Formulation and Revision: Opportunities for Involvement

Carriers develop and revise LMRPs for a variety of reasons at a variety of times. For a listing of circumstances when a carrier **must develop or revise** an LMRP, when a carrier **may develop or revise** an LMRP, and when an existing LMRP **must be reviewed,** [click here] – Editor note: taken to Appendices.

The objective of this tool kit is to encourage psychologists to remain vigilant and ready to seize available opportunities to assure proposed provisions are reflective of psychological research and practice. Therefore, this section will describe new developments that allow increased opportunities for input by psychologists and types of information that can be submitted. The last section segment highlights successful efforts by New York psychologists to revise their LMRP.

Recently Promulgated Requirements for Development and Revision of LMRPs

CMS recently promulgated requirements that carriers post their draft LMRP's and dates of meetings, including provision of a forum for discussion of coverage terms, on the internet (Program Memorandum, Transmittal AB-00-116, dated November 24, 2000). CMS has also recently provided that carriers must consider all LMRP reconsideration requests from providers doing business in a carrier's jurisdiction (Rev. 34, 11-22-02, Medicare Program Integrity Manual, Chapter 13). Specifically,

- Carriers must provide open meetings for the purpose of discussion of draft LMRPs and must allow interested parties to submit scientific, evidence-based information, professional consensus opinions, or any other relevant information

- If time or space are insufficient for all information to be presented in open meeting, then comments provided to the CMD in writing, including by e-mail, must also be given full and equal consideration.

- A draft LMRP must be posted on the carrier's web site, with information on the start and stop date of the comment period and both email and postal addresses for comments. The comment period must be a minimum of 45 days. The web site must also contain an "LMRP status page," setting forth the development, comment and finalization timelines and available comment mechanisms.

- The carrier's web site must provide a summary of comments received concerning the draft LMRP with the carrier's response. The comment/response document needs to be posted on the web for 3-6 months.

- After all comments have been considered and all revisions made as needed, the carrier must provide a minimum notice period of 45 calendar days on the final LMRP.

Who is Expected to Comment?

The carrier must solicit comments and recommendations on the draft LMRP from at least the following sources:

- Appropriate groups of health professionals and provider organizations that may be affected by the LMRP;

- Representatives of specialty societies;

- Other intermediaries/carriers;

- Quality Improvement Organizations within the region;

- Other Carrier Medical Directors within the region;

- General public;

- Carriers should make an effort to ensure that providers with a history of billing for the service are informed of the proposed LMRP and have an opportunity to comment.

What information is used to develop LMRPs?

- In general, all policies providing or limiting coverage under Medicare are supposed to be based on the strongest evidence available.

- The best evidence for policy language is published authoritative evidence derived from definitive randomized clinical trials or other definitive studies.

- If such evidence is not found for the coverage question at issue, then the policy language should reflect general acceptance by the medical community (standard of practice), as supported by sound medical evidence. Sound medical evidence may be derived from scientific data or research studies published in peer-reviewed medical journals, consensus of expert medical opinion, such as recognized authorities in the field, or medical opinion derived from consultations with medical associations or other health care experts.

Where does the carrier start in developing new LMRP language?

- First, the carrier determines if a policy which addresses the issue is already in existence. The carrier may contact other carriers directly, may use the LMRP website, or may use other sources of information.

- If another policy exists, the carrier will likely adopt or adapt the existing language if at all possible.

- If another policy covering the same issue is not found, then the carrier may develop original policy language.

New York Psychologists Success In Revising their LMRP

Recent federal mandates allow psychologists and the general public to comment on Medicare policies.
Monitor on Psychology article, January 2002

BY DEBORAH SMITH
***Monitor* staff**

A new public comment process could expand the type and frequency of psychological and medical services that Medicare will cover for older adults and people with disabilities.

The comment process, mandated by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), requires all Medicare carriers to allow the public to review and comment on the guidelines they use to determine whether medical and psychological services are covered. That new comment period opens the door for psychologists to explain why behavioral services are an important part of many Medicare recipients' care.

"This is a wonderful opportunity for psychologists to have a voice in Medicare policy," says Forrest Scogin, PhD, a member of APA's Committee on Aging (CONA), which is tracking the progress of the new public comment process and its impact on local policies. "Many patients rely heavily on Medicare for access to services, and we know that there are psychological services that can be beneficial for [them]. Unless we advocate for their inclusion, we lose out on opportunities to provide services, and the patients are deprived of the use of those services."

The public comment process applies to the thousands of guidelines that individual Medicare carriers establish to determine reimbursement for services, ranging from psychological assessments to physical therapy to

cataract surgery. These guidelines, called Local Medical Review Policies (LMRPs), vary by state. During the review period, the carrier is now required to post the draft LMRP on a CMS-run Web site (www.draftlmrp.net).

CONA members say that if mental health professionals take advantage of the new public comment process, they could make a substantial difference by lobbying for needed psychological services for older adults and their caregivers.

The new rules not only allow psychologists to educate their Medicare carriers about the importance of these services but also to educate themselves about the LMRP process so that they can properly bill and be reimbursed by Medicare, says Diane Pedulla, JD, director of regulatory affairs in APA's Practice Directorate.

"The LMRP may contain nuances that are critical to accurate billing for services," Pedulla explains. "The LMRPs typically provide more information than is listed in the American Medical Association's billing codes, such as requiring extra documentation."

Psychologists in New York are already taking advantage of the new federal rules by working with their state's Medicare Carrier Advisory Committee (CAC), the group of physicians and other stakeholders that drafts LMRPs and accepts the public's comments.

Last year, for example, the New York State Psychological Association (NYSPA) and its members used their long-standing relationship with the state's CAC to help redraft the state's LMRP on mental health coverage to recognize the importance of mental health services for Medicare recipients, including coverage for those in the early stages of dementia or Alzheimer's disease and appropriate treatment for individuals with serious mental illness.

Initially, the draft policy stipulated that psychological services had to be prescribed and supervised by a psychiatrist, required that patients with depression take medication in order to have psychotherapy, and recommended extremely limited treatment sessions for major psychological disorders.

"We had negotiated our previous LMRP very successfully, so it was extremely unsettling when we received a potentially devastating new policy draft in 2000," explains NYSPA legislative chair Eric Garfinkel, PhD. He and Frank Goldberg, PhD, led a cadre of psychologists concerned about the possible effect of these regulations. They compiled psychological research to show why mental health services are important for older adults and people with disabilities, and wrote a suggested revision of the LMRP.

"We gave them a carefully constructed and comprehensive alternative draft and a thick binder full of supporting documentation," Garfinkel says, noting that the carrier was probably receptive to their suggestions because NYSPA psychologists have been working alongside the state's CAC for years. Garfinkel, Goldberg and their colleagues have attended almost every LMRP meeting, not just those that address mental health concerns.

"Demonstrating our commitment and respect for the process," says Garfinkel, not only helped to establish a strong working relationship, but also allowed them to learn more about how the carrier does business. "You have to help the carrier do its job," he adds, explaining that it's important to understand the forces that can influence the carrier's decisions. "Don't complain about the policy--help them write a new one."

To help others emulate New York's success, CONA and APA's Office on Aging are developing a tool kit that will include information about LMRPs, how CAC meetings work, literature citations for the importance of psychological services for older adults--especially for dementia and Alzheimer's patients--and examples of some successful advocacy efforts.

Part III. Tools for Becoming Involved

LMRP Language: From Bad to Better

This section provides a wide variety of examples of problematic language that has appeared in drafts of LMRPs and that needs to be carefully addressed by psychologists. While these specific examples may or may not be relevant to your local policy language, they demonstrate the need for vigilance and fine-tuned attention to the potential for mistaken and misleading statements about psychological services.

Problem: ***Proposed policy language requires written informed consent for treatment by psychologist:***

Comments: Written informed consent is not mandated for other specific classes of professional services. Consent for billing is in the form of a signature on file. Older adults are often instructed by family not to sign any papers for fear of financial abuse. When a distressed or agitated patient requires assessment or treatment by a psychiatrist, psychologist or other mental health professional, requiring written as opposed to the usual verbal consent for treatment will unnecessarily delay urgently needed care. Psychiatric/psychological interventions, with the exception of medication, are minimally physically intrusive, and can not be performed without the consent and cooperation of the patient. Requiring the patient to sign a legal document at time of acute emotional/behavioral disturbance presents an unjustified barrier to receiving appropriate, timely care.

Problem: ***Proposed policy language requires psychiatrist or physician oversight for psychological services:***

Comments: Except where otherwise required under the Social Security Act, Medicare allows for the independent practice of clinical psychology. The attending physician must order nursing home psychiatric and psychological services. However, psychiatry and psychology are independent professions and psychologists do not require psychiatric oversight.

Problem: ***Proposed policy language includes too narrow definition of reasonable and necessary:***

Bad language: There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning, from the intervention provided.

Better language: There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning, or maintenance of level of functioning when a decline would otherwise by expected.

Problem: ***Proposed policy language includes bias toward one class of provider:***

Bad language: The type, frequency, and duration of services must be medically necessary for the patient's condition under accepted medical and psychiatric practice standards and relate directly to the written treatment plan.

Better language: The type frequency, and duration of services must be medically necessary for the patient's condition under accepted practice standards and relate directly to the written treatment plan.

Bad language: For all psychiatric "incident to" services rendered in the home, skilled nursing home, or partial hospitalization, the physician must be present in the same room as the individual performing the service and participate in the delivery of the service.

Better language: For all psychiatric/psychological "incident to" services rendered in the home, skilled nursing home, or partial hospitalization, the billing provider must be present on the same unit as the individual performing the service and participate in the delivery of the service.

Problem: ***Proposed policy language states or implies that nurses, physician's assistants, or other paraprofessionals may practice psychotherapy:***

Comment: Specific qualifications may vary by state. Check with your state's Nursing Board or Board for Medicine to make sure that the proposed policy language does not go beyond what state licensure allows in the practice of psychotherapy.

Problem: ***Proposed policy language indicates over-reliance on medications in treating older adults or other groups of beneficiaries:***

Bad language: Psychotherapy is an effective adjunctive form of treatment for new psychiatric conditions, while other psychiatric illnesses primarily require treatment with medications.

Comment: This statement is unfounded and reflects a severe bias toward medication in treating older adults.

Bad language: Patients with major depressive disorders and bipolar disorders may also require treatment with medications. These medications must be documented in the

patient's record when psychotherapy is rendered. If the provider of services is not licensed to prescribe medications, they must obtain this information from the prescribing physician. If the patient is not being treated with medications, he must be referred to a psychiatrist for evaluation and treatment with medication before continuing psychotherapy services.

Comment: Medications are often helpful in treating depression. The data of the NIMH collaborative depression study indicate that medication and psychotherapy are about equally effective in the treatment of depression, and that the combined treatment is more effective than either modality alone. As a mater of good clinical practice, most patients should be considered for both medication and psychotherapy and decisions made on a case by case basis. A patient who refuses one effective form of treatment, such as medication, should not be denied access to the alternative effective treatment.

Problem: ***Proposed policy language includes misstatements or overgeneralizations about specific mental health problems:***

Bad language: To benefit from psychotherapy, an individual must be cognitively intact and able to engage the therapist in meaningful verbal interaction.

Better language: To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist (except for family therapy without the patient present, and where interactive psychotherapy is necessary). Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist which allows insight-oriented, behavior-modifying or supportive therapy to be effective. The type and degree of dementia must be taken into account in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should document that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

Bad language: Psychotherapy services for individuals with cognitive impairment can be more effectively carried out with signs and symbols and/or physical aids to communicate.

Comment: This language represents a gross overgeneralization about people with cognitive impairments. A large number of people have subtle cognitive impairments of varying types that go socially and clinically unnoticed. For example, 10 percent of the population in normal public schools are classified as having learning disabilities. In addition, significant numbers are mildly retarded, language impaired, or otherwise developmentally disabled. Similarly, some cognitive changes are common even in the relatively intact elderly, while other individuals are severely and profoundly impaired. We need to be careful not to over generalize and discriminate against a large class of citizens, and in doing so, deny them needed mental health care.

Problem: ***Proposed policy language unduly restricts number of treatment sessions:***

Bad language: Interactive psychotherapy is not a treatment that is required or rendered on an ongoing basis or indefinitely for every patient. Some conditions, such as adjustment disorder or reactive depression require a shorter duration of therapy, i.e., 4-8 sessions to alleviate the condition. Severe depression or schizophrenic conditions might require 15-20 sessions. The only exceptions are certain personality disorders that may require long term therapy, but even these disorders do not need to be treated biweekly or weekly indefinitely.

Comment: If these numbers are meant as treatment limits they are inappropriate. A much better statement provides that the duration of psychotherapy must be individualized for every patient. The coverage for ongoing psychotherapy is available only if there is demonstrable indication that the beneficiary is obtaining continuing benefits. The carrier will monitor the frequency and total number of sessions rendered to individual beneficiaries.

Problem: ***Proposed policy language is inconsistent with evidence:***

Numerous provisions may fit into this category; psychologists reviewing LMRP's must be vigilant for policy provisions that may reflect assumptions by non-psychologists, or may simply be vestiges of obsolete statements about psychology. Examples that have been noted in prior policies include an arbitrarily limited list of diagnoses that are appropriate for group therapy and a statement that only "physicians and psychologists are formally trained in administration and interpretation of psychological tests."

The best response is to note the discrepancy, suggest a more accurate statement, and present the leading evidence that supports the correction.

Problem: ***Policy language presents an ethical dilemma for psychologists:***

Bad language: Documentation for group therapy requires that group note common to all patients be included in each patient's file.

Comment: Documenting the names of other patients in a given patient's chart creates problems of confidentiality and is generally prohibited.

Problem: ***Policy language refers to outmoded test procedures or provides unreasonable time limitations for billing for psychological testing:***

Example: Some policies included references to the MMPI and WAIS-R after the MMPI-2 and WAIS III were in wide practice. Additionally, policies have provided time

limits such as 45 minutes for an older patient to complete the MMPI or other test procedures.

The best response is to update the tests, or suggest that types of tests be substituted for specifically named instruments. Realistic time limits should be demonstrated. Also, behavioral observations are an essential part of psychological testing, and one which has been stressed by the APA Working Group on Older Adults. Make sure reasonable provision of time for scoring and interpretation is included.

Problem: ***Policy language unduly restricts the use of psychological testing:***

Bad language: When a psychiatric condition or the presence of dementia has already been diagnosed, there is no value to the tests, except when there is an observation by the attending physician that there is a significant change in the patient's mental condition and the diagnosis is uncertain.

Comment: Testing has value when it contributes instrumentally to the care of the patient. For example, we may know that a patient has some dementia, but not know to what extent the dementia makes it unsafe to live independently. For a patient for whom caregivers or family have to make such decisions, testing may be essential. The reference to the attending physician oversight is also inappropriate except in nursing home settings.

Bad: Psychological testing is not indicated when the beneficiary has an apparent adjustment disorder or dysphoria after moving to a nursing home.

Comment: This limitation on psychological testing is not in the best interests of patients. Often patients move into nursing homes because of a decline in physical health or ability to care for themselves. The mere fact that they are experiencing dysphoria at the move should not mean that they might not have coexisting problems that need to be investigated. Obviously, many patients who move into nursing homes will feel some degree of adjustment problems that will pass naturally without professional involvement. But they need to be looked at on a case by case basis.

Bad language: Psychological testing for established psychiatric diagnoses will be denied as not medically necessary.

Comment: Testing is not only used to make a diagnosis, but to answer specific questions about the individual's functioning and needs beyond just the diagnosis. If a patient has an established diagnosis of dementia and we need to determine whether he/she has the judgment and cognitive capacity to care for him/herself in specific, relevant situation, the diagnosis may remain dementia, but the testing was necessary.

Examples of Recent Developments in Coverage for Psychological Services

Several states have recently changed their policy language to more accurately reflect psychology's current understanding of the course of dementia as well as the current state of available treatment options. Psychologists were heavily involved in the process resulting in beneficial changes in New York, Connecticut and Minnesota.

Specific Changes in Policy Language

The New York LMRP was revised to include consideration of the multiple stages of dementia in determining appropriate treatment:

> To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist (except for family therapy without the patient present, and where interactive psychotherapy is necessary). Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent establishment of a relationship with the therapist which allows insight-oriented, behavior-modifying or supportive therapy to be effective. The type and degree of dementia must be taken into account in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should document that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.

The New York LMRP also benefited from input by psychologists in its coverage provisions for psychological and neuropsychological testing. It provides that:

> Additional testing after a diagnosis of dementia may be considered reasonable and necessary if it can be expected to aid in evaluation of a patient's capacity to function in a given situation, to have a significant impact on management of the patient, or to help tailor therapeutic techniques.

On a more general level, the New York LMRP departs from a rigid medical model by providing the following language in place of reference to "malformed body members" (the traditional language used in older policies to support medical necessity):

> There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning, or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorder.

LMRPs in Connecticut and Minnesota were recently revised to include consideration of comorbid conditions with dementia, which may also bear on medical necessity and result in access to care for more older adults:

> Dementia and Alzheimer's disease in nursing homes is fairly common. Most of the time the attending physician, usually a general internist, family practitioner or geriatrician manages these patients and it is not medically necessary to follow these patients more frequently than once a month. Medicare provides coverage for all medically necessary evaluations.
>
> Patients with dementia with complications such as paranoia, agitation, and depression may require psychiatric/psychotherapeutic care to adequately assess their emotional and behavioral symptoms, their mental status and their ongoing treatment needs.
>
> The standard of care during the initial evaluation by psychiatry in such patients includes pertinent medical, pharmacologic, laboratory, psychiatric and environmental findings that may have influenced the new/additional symptoms and may influence further care.
>
> After the initial evaluation and stabilization of the psychiatric complications(s), the follow-up should be infrequent and for the purpose of monitoring the clinical status. As the patient becomes stable on the treatment, the intervals between the evaluations should become less frequent.

Change of National Policy on Coverage Determinations

A recent CMS Program Memorandum indicates current awareness of the problem of automatic denial of claims when a diagnosis of dementia is present. Transmittal AB-01-135, dated September 25, 2001, entitled "Medical Review of Services for Patients with Dementia," states that carriers may not include provisions that result in automatic denial of claims based solely on a diagnosis of dementia. The memorandum notes that new developments in neuropsychiatric testing enable physicians and psychologists to diagnose some dementias at early stages so that throughout the ensuing disease process, many patients may benefit from pharmacologic, physical, occupational, speech-language, and other therapies.

Relevant to psychologists' complaints that claims appear to be automatically denied even where the language of the LMRP does not support the practice, the Program Memorandum further states that carriers "may not use ICD-9 codes for dementia alone as a basis for determining whether a Medicare covered benefit was reasonable and necessary because these codes do not define the extent of a beneficiary's cognitive impairment."

See CONA's initial 2001 report *Overview of Medicare Coverage for Psychological Services for Patients with Diagnoses of Dementia or Alzheimer's Disease* http://www.apa.org/pi/aging/overviewmedcare.html

Sample Correspondence

General tips for Securing Input

Although individual psychologists can raise the awareness of the local carrier of areas of import to psychology, most likely, initial efforts to secure psychologists' input into the draft LMRP development process will reflect preliminary work and planning by a committee of psychologists. This may be the state-level psychological organization [link to list of SPAs] or other group of psychologists. The Carrier Advisory Committee process has built-in respect for efforts and presentations by professional societies, so that it may be a good idea for the initial and ongoing communications to demonstrate an organized group.

Corrrespondence and other interactions with the Carrier Medical Director and the Carrier Advisory Committee should therefore strive to: a) reflect the efforts of a specialized group of psychologists with collective knowledge and experience in the field; b) should emphasize the ability of psychologists to be of assistance to those responsible for policy language; and c) should emphasize a scientific, evidence-based approach to specific items currently at issue.

Letter to request a meeting with the Carrier Medical Director

Dear Dr. [name of CMD]:

As the [name of group or committee], we have been charged with the task of representing the interests of psychologists and their patients in the area of Medicare coverage for necessary psychological services. We have been following with interest the recently proposed LMRP draft, particularly sections ____, providing policy language regarding ______________________.

We believe that we may be of particular assistance to the Carrier Advisory Committee in making final decisions about the proposed language, based on our specialized knowledge of the clinical research supporting current practice in this area, as well as our collective experience with patients requiring these very services.

Accordingly, we are writing to request a brief meeting with you, in the hopes of discussing the best possible way for us to be of assistance in the development of this LMRP. We have information and evidence which bears directly on the decisions to be made, and would like to discuss further the best format for providing it in the most helpful manner.

Written comments to proposed policy language:

Dear Dr. [name of CMD]:

We are writing on behalf of [ ], an organization of psychologists who [your area of expertise]. We would like to express our concern regarding Note 11 under Section III: Psychiatric Therapeutic Procedures of your local medical review policy (LMRP) for psychiatry and psychology services. This provision states, in pertinent part:

> In a nursing home setting, if a patient is treated for a mental health problem, psychotherapy is medically inappropriate unless the treating physician recognizes that there is an inadequate response to medical treatment and he/she specifically authorizes psychotherapy. In the absence of such authorization, psychotherapy would be considered professionally unethical and inappropriate, and would constitute a duplicative service.

This limitation is inconsistent with medical science and clinical practice in several respects. Declaring psychotherapy to be "medically inappropriate unless the treating physician recognizes that there is an inadequate response to medical treatment" is inconsistent with empirical research. It has been demonstrated that, in both younger and older adults, psychotherapy in conjunction with pharmacotherapy is significantly more effective in treating mental health problems than is pharmacotherapy alone (Arean & Cook, 2002; de Jonghe, Kool, van Aalst, Dekker, & Peen, 2001). Moreover, there are instances when psychological interventions are more appropriate than medication, especially for older adults, and even more so nursing home residents, who are at increased risk for adverse pharmacological side effects and drug interactions. Note 11 further seems to encourage the prescribing of medications in nursing homes, which is in contradiction to federal monitoring efforts that are geared toward decreasing the use of medication by long-term care residents when other treatments are available. In addition, benefits provided by psychotherapy should not be considered "duplicative," as Note 11 indicates. Rather, psychotherapy frequently offers benefits that are distinct from, or complementary to, the benefits of medication therapy. It is also important to recognize that many psychotropic medications (e.g., antidepressants) typically require several weeks to take effect, whereas psychotherapy can provide more immediate relief. This is an especially significant consideration with individuals in severe distress. Additionally, Note 11, when read in its entirety, suggests that mental illness in nursing home residents consists exclusively of dementia-related symptoms. Although dementia is highly prevalent in nursing homes, other mental disorders are highly prevalent in this setting (Strahan & Burns, 1991), including depression, anxiety, and personality disorders in the absence of dementia.

We assume that one intention of Note 11 is to coordinate psychological services with medical care. This important collaboration is accomplished by the CMS Medicare requirement that psychologists inform a patient's primary physician when the patient is receiving psychological services. However, requiring that physicians specifically authorize psychotherapy likely causes many older adults with significant mental health problems to go untreated. Research has shown that physicians commonly fail to detect mental disorders in elderly individuals, which are often mistakenly attributed to organic illness or normal age-related changes (Mackenzie, Gekoski, & Knox, 1999). Less than

10% of nursing home residents in need of mental health care receive treatment, including medication (AARP Public Policy Institute, 1994). The AARP Public Policy Institute concluded in its report of mental health services in nursing homes, “Despite the high prevalence of mental disorders among nursing home residents and the beneficial impact that mental health treatment could have for many of these residents, mental health services are scarce in this setting” (AARP Public Policy Institute, 1994, p. 45). Furthermore, physicians are often not able to closely monitor psychological and behavioral changes in patients residing in long-term care facilities. Psychologists providing psychotherapy, however, are in a better position to evaluate changes in the patient and provide information to the physician about responses to treatment.

As it is written, Note 11 is discrepant with Chapter 13 of the Medicare Program Integrity Manual (PIM), which requires that “Contractors develop LMRPs by considering medical literature, the advice of local medical societies and medical consultants and public comments” (PIM, Ch. 13, Sec. 1.3). The PIM further requires that LMRPs be based on “the strongest evidence available” (PIM, Ch. 13, Sec. 7.1). In light of its inconsistency with medical science, current medical evidence, and clinical practice, we request that you remove the section from Note 11 quoted above from your LMRPs.

Thank you for your attention to our concerns. Please feel free to contact us if you have any questions or would like to discuss this matter further.

Empirical Evidence for Psychological Services

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Resources

The main source of information and linkage to Medicare carriers and local medical review policies http://www.lmrp.net

The Medicare Coverage Database includes National Coverage Determinations, National Coverage Analyses and LMRPs. http://cms.hhs.gov/coverage.

Medicare Program Integrity Manual, Chapter 13:
http://www.hcfa.gov/pubforms/83_PIM/PIM83c13.htm

View monthly updates by Medicare carrier on the web:
http://www.lmrp.net/ViewUpdatesStep1.asp

HHS OIG Report on Part B Policies for Mental Health Services
http://oig.hhs.gov/oei/reports/oei-03-99-00132.pdf

ABA/Alzheimer's Medicare Advocacy Project
Contact Leslie Fried Friedl@staff.abanet.org

Alzheimer's Association
www.alz.org

Medicare Learning Network
http://www.cms.hhs.gov/medlearn

Medicare Rights Center
www.medicarerights.org

CMS Regional Office Jurisdictions and Contact Information,
http://www.cms.hhs.gov/about/regions/professionals.asp

Region I: Boston
Bill MacKenzie (William)
617.656.3857

Region II: New York
Kelli Singleton
212.264.8528

Region III: Philadelphia
Barbara Cerbone
215.861.4320

Region IV: Atlanta
Neil Logue
404.562.7382

Region V: Chicago
Greg Chesmore

312.353.1487

Region IV: Dallas
Pamela Kanawyer
214.767.6419

Region VII: Kansas City
Uvonda Meinholdt
816.426.5783 ext. 3444

Region VIII: Denver
Diane Livesay
303.844.7057

Region IX: San Francisco
Julia Cohen
415.744.3781

Region X: Seattle
Malvin White
206.615.2425

State Psychological Associations are listed at http://www.apa.org/practice/refer.html

APA Practice Directorate can answer general questions about Medicare and reimbursement issues. Call 202-336-5889 or go to www.apa.org/practice

For additional information related to psychological practice, call 202-336-5800 or go to www.apa.org/practice

The Medicare Handbook answers general questions about Medicare, such as how to become a Medicare provider. http://www.apa.org/practice/medtoc.html

APA Division 12 Section II (Clinical Geropsychology) was established to further the professional goals and interests of psychologists practicing with older adults, teaching the clinical psychology of aging, or conducting related clinical research. The Section has a Public Policy Committee that is active in Medicare Issues. Contact: Margaret Norris, Public Policy Chair margienorris@hotmail.com

Psychologists In Long Term Care is a national network for psychologists working in long-term care settings. Part of its mission is to improve the access and quality of mental health services in long-term care settings. Contact: Margaret Norris, Coordinator

margienorris@hotmail.com or Nick Stilwell, Director of Membership at GNICK@NETCARRIER.COM

The APA Office on Aging maintains an Aging Issues Web Page that provides information on a wide range of aging issues for professionals, older adults and their families. http://www.apa.org/pi/aging

What Is CONA?

CONA is the American Psychological Association's Committee of Aging. It receives staff support from APA's Office on Aging, which in turn is housed under the APA Public Interest Directorate http://www.apa.org/pi/aging/homepage.html

The goal of CONA is to advance psychology as a science and profession and as a means of promoting human welfare by ensuring that older adults, especially the growing numbers of older women and minorities, receive the attention of the Association. CONA works toward the optimal development of older adults, expanded scientific understanding of adult development and aging, and the delivery of appropriate psychological services to older persons.

The APA Committee on Aging (CONA) and Office on Aging have embarked on the Local Medical Review Policy Project to work toward increasing the availability and coverage of psychological services for older adults under Medicare. For more information on CONA's Medicare LMRP Project http://www.apa.org/pi/aging/lmrp/

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Institute of Rural Health
Idaho State University
Pocatello, Idaho

Antonette Zeiss, PhD
(1/01 – 12/03)
VA Palo Alto Health Care System
Palo Alto, California

Submissions

The LMRP Project welcomes submissions from practitioners in all 50 states. If you have experience with your CMD or CAC or past correspondence that would be useful to other psychologists becoming involved in the LMRP process, please submit your comments, suggestions, and copies of correspondence to:

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Appendices (earlier pgs will link to these pages for more info)

Hierarchy of laws, policies and guidelines that control Medicare claims

National Coverage Determinations (NCD)

These are developed by CMS to describe circumstances and limitations of Medicare coverage for a specific procedure or device. They are published as CMS Program Instructions. Once published, NCD's operate at a high level of authority. They are binding on all Medicare carriers. Also, if a claim dispute arises, it may be decided by an Administrative Law Judge. These judges are also bound by NCD's.

Coverage Provisions in Interpretive Manuals

These are coverage instructions published by CMS other than National Coverage Determinations. They are used to further describe circumstances and limitations of Medicare coverage. Once published, they also become authoritative; they, too, are binding on all Medicare carriers. If a Carrier's current language is inconsistent with a new CMS determination, the Carrier must change its policy and must publish or provide a link to the policy change on its own website. Carriers are also required to include these changes in their coverage bulletins as soon as possible.

Articles

Carriers may include in provider bulletins, websites, and educational materials general discussion regarding practice standards, existing National Coverage Determinations, Program Memoranda issued by CMS, coverage provisions in an interpretive manual, or existing LMRPs.

Individual Claim Determinations

Carriers may review claims on either a prepayment or postpayment basis, regardless of whether any of the above types of policies applies to the service. Usually, carriers are not permitted to use a system of automatic denial for categories of claims.

When do carriers develop new policy language?

There are circumstances when a carrier must develop or revise an LMRP, when a carrier may develop or revise an LMRP, and when an existing LMRP must be reviewed.

When MUST a carrier develop or revise an LMRP?

A carrier is obligated to develop an LMRP when it wishes to introduce a new circumstance of automated review. In other words, when a carrier has taken the position that a service is never covered under certain, identifiable circumstances and it wishes to establish an automatic denial process (usually by way of a computer program that recognizes the claim), it must develop LMRP language to set forth the coverage limitation and terms of automatic denial. A new LMRP is not necessary if a National Coverage Determination or interpretive manual supports the automatic review.

When MAY a carrier develop or revise an LMRP?

A carrier may develop or revise an LMRP when it has identified a widespread problem that demonstrates a significant risk to the Medicare trust funds.

A carrier may develop or revise an LMRP when it has determined that policy language is needed to assure beneficiary access to care.

A carrier may develop or revise an LMRP when frequent denials are issued or anticipated.

A carrier may develop or revise an LMRP when it has assumed the LMRP development workload of another carrier and is undertaking an initiative to create uniform LMRPs across its multiple jurisdictions

When MUST a carrier review an existing LMRP?

As of October 2001, all carriers must review all LMRPs annually to ensure that they are consistent with National Coverage Determinations, coverage provisions in interpretive manuals, national payment policies, and national coding policies.

In addition, a carrier must review an existing LMRP within 90 days of the publication of a new or revised National Coverage Determination, a new or revised coverage provision in an interpretive manual, or a change to national payment policy.

A carrier must also review an existing LMRP within 120 days of publication of an update to the ICD-9 or HCPCS coding systems.

Notice and Comment Period for New LMRPs

What are the notice and comment requirements?

CMS recently promulgated requirements that carriers post their draft LMRP's and dates of meetings, including provision of a forum for discussion of coverage terms, on the internet.

Program Memorandum, Transmittal AB-00-116, dated November 24, 2000 provides that carriers must allow for the submission of information from the public to assure that the development of LMRPs occurs through a public and open process.

Carriers must provide open meetings for the purpose of discussion of draft LMRPs and must allow interested parties to submit scientific, evidence-based information, professional consensus opinions, or any other relevant information.

If time or space are insufficient for all information to be presented in open meeting, then comments provided to the CMD in writing, including by e-mail, must also be given full and equal consideration.

The comment period must be a minimum of 45 days.

Carriers also have web-based requirements for notice and comment

A draft LMRP must be posted on the carrier's web site, including the start and stop date of the comment period and both email and postal addresses for comments.

The carrier's web site must also contain an "LMRP status page," setting forth the draft LMRP title, date of release for comment, email and postal address for comments, end date for comment period, current status, actual date of release of final LMRP, and web site link to final LMRP.

The carrier's web site must provide a summary of comments received concerning the draft LMRP with the carrier's response. The comment/response document needs to be posted on the web for 3-6 months.

The carrier must also complete a draft LMRP form on www.draftLMRP.net within 2 business days of the draft being posted to the carrier's site.

After all comments have been considered and all revisions made as needed, the carrier must provide a minimum notice period of 45 calendar days on the final LMRP.

Final LMRP Publication Requirements

Carriers must make final LMRPs public by special bulletin, update to a provider manual, or inclusion in a newsletter.

Carriers must post all final LMRPs on their web site.

Carriers must update www.LMRP.net when they issue a new or revised LMRP.

Who is expected to comment?

The carrier must solicit comments and recommendations on the draft LMRP from at least the following sources:

Appropriate groups of health professionals and provider organizations that may be affected by the LMRP;

- Representatives of specialty societies;
- Other intermediaries/carriers;
- Quality Improvement Organizations within the region;
- Other Carrier Medical Directors within the region;
- General public;
- Carriers should make an effort to ensure that providers with a history of billing for the service are informed of the proposed LMRP and have an opportunity to comment.