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National Coverage Determination Member Notification

The Centers for Medicare & Medicaid Services (CMS) require that we notify health plan members of National Coverage Determinations (NCDs). NCDs are official directives issued by Medicare that expand coverage to a specified service or set of services for Medicare beneficiaries. In some cases, services addressed by NCDs will be provided to you under your current health plan. In other cases the services noted in the NCD are covered under Original Medicare.

To inquire about receiving the service outlined in the NCD, you may consult with your primary care provider or contact the health plan at the numbers below. Your primary care provider can help to determine if these services are medically indicated for your condition.

Please note that normal co-payments and deductibles associated with your plan may apply. Services covered under Original Medicare are subject to Medicare coinsurance.

For more information related to this NCD and questions about your coverage, please contact Member Services, 8:00 a.m. – 8:00 p.m. seven days a week:

California:	1-800-443-0815 (TTY 711)
Colorado:	1-800-476-2167 (TTY 711)
Georgia:	1-800-232-4404 (TTY 711)
Hawaii:	1-800-805-2739 (TTY 711)
Maryland, Washington DC, & Virginia:	1-888-777-5536 (TTY 711)
Oregon/Southwest Washington	1-877-221-8221 (TTY 711)
Washington:	1-888-901-4600 (TTY 711)

Service:	Effective Date:	Description:	Link to access NCD on Medicare's website:
National Coverage Determination (NCD) Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention	**9/30/2024**	Effective September 30, 2024, Centers for Medicare & Medicaid Services (CMS) issued the National Coverage Determination (NCD) on Preexposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention transitioning coverage for PrEP from Part D to Part B. CMS covers Preexposure Prophylaxis (PrEP) and other related services to prevent HIV under Part B preventive coverage without costsharing. For individuals being assessed for or using PrEP to prevent HIV o Part B covers furnishing HIV PrEP using antiretroviral drugs, including the supplying or dispensing of these drugs and the administration of injectable PrEP. Part B coverage covers all the following as an additional preventive service: a) Up to eight individual counseling visits every 12 months, that include HIV risk assessment (initial or continued assessment of risk), HIV risk reduction, and	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=310

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		medication adherence. Counseling must be furnished by a physician or other health care practitioner. Individuals must be competent and alert at the time that counseling is provided. b) Up to eight HIV screening tests every 12 months. c) A single screening for hepatitis B virus.	
National Coverage Determination (NCD) Stem Cell Transplantation	**3/6/2024**	○ Effective for services performed on after March 6, 2024, the Centers for Medicare and Medicaid Services (CMS) covers allogeneic hematopoietic stem cell transplant using bone marrow, peripheral blood or umbilical cord blood stem cell products for Medicare patients with myelodysplastic syndromes who have prognostic risk scores of: ○ ≥ 1.5 (Intermediate-2 or high) using the International Prognostic Scoring System (IPSS), or ○ ≥ 4.5 (high or very high) using the International Prognostic Scoring System - Revised (IPSS-R), or ○ ≥ 0.5 (high or very high) using the Molecular International Prognostic Scoring System (IPSS-M). ○ Stem cell transplantation is a process in which stem cells are harvested from either a patient's (autologous) or donor's (allogeneic) bone marrow or peripheral blood for intravenous infusion.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=366
National Coverage Determination (NCD) Percutaneous Transluminal Angioplasty (PTA)	**10/11/2023**	• Effective October 11, 2023, the Centers for Medicare and Medicaid Services (CMS) covers Percutaneous Transluminal Angioplasty (PTA) of the carotid artery concurrent with stenting with the placement of an FDA approved carotid stent with an FDA approved or cleared embolic protection device, for Medicare beneficiaries. The changes include: ○ The expanded coverage applies the percentage requirements for patients with symptomatic carotid artery stenosis (CAS) ≥50%, and for patients with asymptomatic CAS ≥70%. ○ An assessment is required before and after CAS by an appropriately certified provider; ○ Decision-making is required to be shared between provider(s) and patient; ○ Facility standards must establish and maintain institutional and physician standards to support a dedicated carotid stent program including the granting of clinical privileges, maintaining appropriate supporting personnel and equipment, monitoring patient outcomes, and ensuring continuous quality improvement.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=366

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Service:	Effective Date:	Description:	Link to access NCD on Medicare's website:
National Coverage Determination (NCD) Home Use of Oxygen	**9/27/2021**	○ Effective September 27, 2021: ○ oxygen therapy and oxygen equipment are covered in the home for acute or chronic conditions, short- or long- term, when the patient exhibits hypoxemia as defined below. ▪ Initial claims for oxygen therapy for hypoxemic patients must be based on the results of a clinical test ordered and evaluated by the treating practitioner. ▪ Required qualifying arterial blood gas or oximetry studies must be performed at the time of need. ▪ Patients exhibiting hypoxemia are defined using clinical criteria specified in this NCD regarding arterial PO2 and arterial oxygen saturation levels in particular situations and/or additional signs/symptoms/disease processes (see link below for details). In reviewing the arterial PO2 levels and the arterial oxygen saturation percentages specified in this NCD, the Medicare Administrative Contractors (MACs) must take into account variations in oxygen measurements that may result from such factors as the patient's age, the patient's skin pigmentation, the altitude level, or the patient's decreased oxygen carrying capacity ○ CMS will not cover oxygen therapy and oxygen equipment in the home in the following circumstances: ▪ angina pectoris in the absence of hypoxemia; or ▪ breathlessness without cor pulmonale or evidence of hypoxemia; or ▪ severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; or ▪ terminal illnesses unless they affect the ability to breathe. ○ the MAC may determine reasonable and necessary coverage of oxygen therapy and oxygen equipment in the home for patients who are not described in subsection B or precluded by subsection C of this NCD. Initial coverage for patients with other conditions may be limited to the shorter of 120 days or the number of days included in the practitioner prescription at MAC discretion. Oxygen coverage may be renewed if deemed medically necessary by the MAC.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=169&ncdver=2&doctype=all&timeframe=60&sortBy=updated&bc=20
National Coverage Determination	**9/27/2021**	○ Effective September 27, 2021, the CMS removed the NCD for home oxygen use to treat cluster headaches.	https://www.cms.gov/medicare-coverage-database/view/ncd.asp

(NCD) Removal Home Oxygen Use to Treat Cluster Headache (CH)		The purpose of the Change Request is to revise Section 240.2 and Section 240.2.2 of the National Coverage Determination (NCD) Manual (Pub. 100-03), Chapter 1, Part 4, and to inform the Medicare Administrative Contractors (MAC)s of the changes associated with these NCDs effective September 27, 2021. The Centers for Medicare & Medicaid Services finalized revisions to two separate, but medically related, NCDs for oxygen therapy and oxygen equipment in the home.	x?ncdid=343&ncdver=2&doctype=all&timeframe=60&sortBy=updated&bc=20
National Coverage Determination (NCD) Removal Positron Emission Tomography (PET) Scans	**1/1/2022**	○ Effective January 1, 2022, the Centers for Medicare & Medicaid Services removed the umbrella national coverage determination (NCD) for Positron Emission Tomography (PET) Scans. All PET indications currently covered or non-covered under NCDs under section 220.6 remain unchanged and MACs shall not alter coverage for indications covered under NCDs.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=211&ncdver=6&doctype=NCD&timeframe=30&sortBy=updated&bc=20
National Coverage Determination (NCD) Removal Enteral and Parenteral Nutritional Therapy	**1/1/2022**	○ Effective January 1, 2022, the Centers for Medicare & Medicaid Services determined that no national coverage determination (NCD) is appropriate at this time for Enteral and Parenteral Nutritional Therapy.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=242&ncdver=2&doctype=NCD&timeframe=30&sortBy=updated&bc=20

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National Coverage Determination (NCD) Lung Cancer Screening with Low Dose Computed Tomography (LDCT)	**2/10/2022**	○ The purpose of this Change Request (CR) is to inform interested parties that effective February 10, 2022, CMS is expanding beneficiary eligibility for screening for lung cancer with Low dose computed tomography (LDCT). ○ Lung cancer is the third most common cancer and the leading cause of cancer deaths in the United States. Computed tomography (CT) is an imaging procedure that uses specialized x-ray equipment to create detailed pictures of areas inside the body. LDCT is a chest CT scan performed at settings to minimize radiation exposure compared to a standard chest CT. CMS has determined that the evidence is sufficient to cover, under Medicare Part B, a lung cancer screening counseling and shared decision-making visit, and for appropriate beneficiaries, annual screening for lung cancer with LDCT, as an additional preventive service benefit under the Medicare program, only if all of the following eligibility criteria are met. Beneficiary Eligibility Criteria Beneficiaries must meet all of the following eligibility criteria: ○ Age 50 – 77 years; ○ Asymptomatic (no signs or symptoms of lung cancer); ○ Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack =20 cigarettes); ○ Current smoker or one who has quit smoking within the last 15 years; and, ○ Receive an order for lung cancer screening with LDCT. Counseling and Shared Decision-Making Visit Before the beneficiary's first lung cancer LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that meets all of the following criteria, and is appropriately documented in the beneficiary's medical records: ○ Determination of beneficiary eligibility; ○ Shared decision-making, including the use of one or more decision aids; ○ Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and, ○ Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions. Reading Radiologist Eligibility Criteria The reading radiologist must have board certification or	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=364&ncdver=2&doctype=NCD&timeframe=120&sortBy=updated&bc=20

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		board eligibility with the American Board of Radiology or equivalent organization. Radiology Imaging Facility Eligibility Criteria Lung cancer screening with LDCT must be furnished in a radiology imaging facility that utilizes a standardized lung nodule identification, classification, and reporting system.	
National Coverage Determination (NCD) Home Use of Oxygen	**1/1/2023**	Effective September 27, 2021, Implementation Date January 1, 2023, National Coverage Determination (NCD) for Home Use of Oxygen. Section B of the NCD discusses that/how oxygen therapy and oxygen equipment is covered in the home for certain acute and chronic conditions. Section C of the NCD discusses the conditions under which CMS will not allow coverage in the home of oxygen therapy and oxygen equipment. Section D of the NCD advises that the MAC may determine reasonable and necessary coverage of oxygen therapy and oxygen equipment in the home for patients who are not described in Section B and Section C of the NCD. In the circumstances where Section D is applicable for patient with other conditions, initial coverage may be limited to the shorter of 90 days or the number of days included in the practitioner prescription at MAC discretion and oxygen coverage may be renewed if deemed medically necessary by the MAC. Additionally, the MAC may also allow beneficiaries who are mobile in the home and would benefit from the use of a portable oxygen system in the home, to qualify for coverage of a portable oxygen system either 1) by itself, or 2) to use in addition to a stationary oxygen system. Kaiser follows Medicare Coverage for this benefit, and this NCD provides for more flexibility for Medicare Advantage plans such as Kaiser Permanente in administration of home use of oxygen as described in Section D	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=169&ncdver=2&doctype=all&timeframe=60&sortBy=updated&bc=20
National Coverage Determination (NCD) Monoclonal Antibodies Directed Against Amyloid For The Treatment Of Alzheimer's Disease (AD)	**12/12/2022**	• Effective April 7, 2022, Implementation Date December 12, 2022, CMS issued a National Coverage Determination (NCD) for Monoclonal Antibodies (mAbs) Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD). • Antiamyloid-beta monoclonal antibodies (antiamyloid mAbs) are laboratory-made proteins designed to bind a specific substance in the body, with the goal of marking it for destruction by the body's immune system. Scientists design various mAbs as treatments with the goal of targeting and neutralizing or clearing infections (like the	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=375&ncdver=1&keyword=Monoclonal%20Antibodies%20Directed%20Against%20Amyloid%20for%20the%20Treatment%20of%20Alzheim&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1

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		COVID-19 virus), cancer cells, and in the case of AD, amyloid accumulation in the brain. • CMS covers Food and Drug Administration (FDA)-approved monoclonal antibodies (mAbs) directed against amyloid for the treatment of AD when furnished in accordance with the coverage criteria below, under coverage with evidence development (CED) for patients who have a clinical diagnosis of mild cognitive impairment (MCI) due to AD or mild AD dementia, both with confirmed presence of amyloid beta pathology consistent with AD. • Section B of the NCD lists the nationally covered indications that may be covered: (See attached NCD) ▪ FDA approved mAbs directed against amyloid for the treatment of AD based upon evidence of efficacy from a change in a surrogate endpoint (e.g., amyloid reduction) considered as reasonably likely to predict clinical benefit may be covered in a randomized controlled trial conducted under an investigational new drug (IND) application. ▪ FDA approved mAbs directed against amyloid for the treatment of AD based upon evidence of efficacy from a direct measure of clinical benefit may be covered in CMS-approved prospective comparative studies. ▪ CMS-approved studies of a mAbs directed against amyloid (antiamyloid mAb) approved by FDA for the treatment of AD based upon evidence of efficacy from a direct measure of clinical benefit must address specific questions specified in the NCD • Section C of the NCD lists the nationally non-covered indications. o Monoclonal antibodies directed against amyloid for the treatment of AD provided outside of an FDA-approved	

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		randomized controlled trial, CMS approved studies, or studies supported by the NIH, are nationally non-covered. • Medicare Advantage plans are required to cover the cost of items and services in CMS approved CED studies unless CMS determines the significant cost threshold is exceeded (see Chapter 4, Section 10.7.3, of the Medicare Managed Care Manual). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf	
National Coverage Determination (NCD) Ambulatory Electroencephalographic (EEG) Monitoring.	**1/1/2023**	Effective **January 1, 2023**, the Centers for Medicare & Medicaid Services retired the National Coverage Determination (NCD) for Ambulatory Electroencephalographic (EEG) Monitoring. CMS periodically identifies and proposes to remove NCDs through public notice and comment rulemaking. In the CY 2023 Physician Fee Schedule, CMS determined that the NCD for EEG Monitoring no longer contains clinically pertinent and current information or no longer reflects current medical practice. In the CY 2023 Physician Fee Schedule Final Rule, CMS finalized a proposal to remove NCD 160.22 EEG Monitoring. In the absence of this NCD, coverage determinations will revert to the Medicare Administrative Contractor (MAC) discretion effective for claims with dates of service on or after 01/01/2023.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=215&ncdver=2&doctype=NCD&timeframe=30&sortBy=updated&bc=20
National Coverage Determination (NCD) Colorectal Cancer Screening Tests	**1/1/2023**	**Beginning January 1, 2023**, the minimum age for Medicare-covered Fecal Occult Blood Tests (FOBT) (Immunoassay, or immunochemical fecal occult blood tests (iFOBT), Guaiac fecal occult blood tests (gFOBT)) to detect colon cancer, is reduced to 45 years and older, covered once every three years for Medicare beneficiaries who meet all other existing coverage criteria. **Beginning January 1, 2023**, the minimum age for Medicare-covered Cologuard™ – Multi-target Stool DNA (sDNA) Test screening stool or fecal DNA, (deoxyribonucleic acid), (sDNA) to detect colon cancer, is reduced to 45 years and older, covered once every three years for Medicare beneficiaries who meet all other existing coverage criteria. These policy updates to expand coverage of colorectal cancer (CRC) screening by reducing the age of coverage	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=281&ncdver=7&doctype=NCD&timeframe=30&sortBy=updated&bc=20

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		from age 50 to age 45 result from changes specified in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule (87 FR 69404), published in the Federal Register on 11/18/2022. In addition the final rule also expands the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based test returns a positive result.	
National Coverage Determination (NCD) Cochlear Implantation	**9/26/2022**	**Effective for services performed on or after September 26, 2022,** cochlear implantation is **expanded** to include coverage for cochlear implantation for treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss in individuals who demonstrate limited benefit from amplification. Limited benefit from amplification is defined by test scores of less than or equal to *60%* correct in the best-aided listening condition on *recorded* tests of open-set sentence *re*cognition. *P*atients *must* meet all of the following *criteria*. Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids; Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation; Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; No contraindications to surgery; and The device must be used in accordance with Food and Drug Administration (FDA)- approved labeling. Medicare beneficiaries not meeting all of the coverage criteria for cochlear implantation listed above are deemed not eligible for Medicare coverage except for the following: CMS may provide coverage of cochlear implants for beneficiaries not meeting the coverage criteria listed in Section B when performed in the context of FDA-approved category B investigational device	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=245&ncdver=3&doctype=NCD&timeframe=30&sortBy=updated&bc=20

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		exemption clinical trials as defined at 42 CFR 405.201 or as a routine cost in clinical trials under section 310.1 of the National Coverage Determinations Manual titled Routine Costs in Clinical Trials.	
National Coverage Determination (NCD) Home Use of Oxygen	**1/1/2023**	Effective September 27, 2021, Implementation Date January 1, 2023, National Coverage Determination (NCD) for Home Use of Oxygen. Section B of the NCD discusses that/how oxygen therapy and oxygen equipment is covered in the home for certain acute and chronic conditions. Section C of the NCD discusses the conditions under which CMS will not allow coverage in the home of oxygen therapy and oxygen equipment. Section D of the NCD advises that the MAC may determine reasonable and necessary coverage of oxygen therapy and oxygen equipment in the home for patients who are not described in Section B and Section C of the NCD. In the circumstances where Section D is applicable for patient with other conditions, initial coverage may be limited to the shorter of 90 days or the number of days included in the practitioner prescription at MAC discretion and oxygen coverage may be renewed if deemed medically necessary by the MAC. Additionally, the MAC may also allow beneficiaries who are mobile in the home and would benefit from the use of a portable oxygen system in the home, to qualify for coverage of a portable oxygen system either 1) by itself, or 2) to use in addition to a stationary oxygen system. Kaiser follows Medicare Coverage for this benefit, and this NCD provides for more flexibility for Medicare Advantage plans such as Kaiser Permanente in administration of home use of oxygen as described in Section D..	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=169&ncdver=2&doctype=all&timeframe=30&sortBy=updated&bc=20
National Coverage Determination (NCD) Seat Elevation Equipment (Power Operated) on Power Wheelchairs	**5/16/2023**	**Effective for services performed on or after May 16, 2023**, individuals using complex rehabilitative power-driven wheelchairs are covered for power seat elevation equipment when the following conditions are met: Beneficiary has undergone a specialty evaluation performed by a licensed/certified medical professional who has specific training and experience in rehabilitation wheelchair evaluations and the evaluation confirms the beneficiary is able to safely operate the seat elevation equipment in the home, and at least one of the following apply: Can perform weight bearing transfers to/from the power wheelchair while in the home with or without caregiver assistance and/or the use of assistive equipment using either their upper extremities during a non-level (uneven) sitting transfer and/or their lower extremities during a sit to stand transfer; ***or***,	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=376&ncdver=1&doctype=NCD&timef

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		Requires a non-weight bearing, dependent transfer to/from the power wheelchair while in the home. Transfers may be accomplished with or without a floor or mounted lift; ***or***, Can reach from the power wheelchair to complete one or more mobility related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home. MRADLs may be accomplished with or without caregiver assistance and/or the use of assistive equipment.	

National Coverage Determination (NCD) Beta Amyloid Positron Tomography in Dementia and Neurodegenerative Disease (RETIRED)	**10/13/2023**	Effective October 13, 2023, CMS removed NCD 220.6.20, ending CED for PET beta amyloid imaging, coverage determinations to be made on a case-by-case basis.	https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=356&ncdver=2&doctype=NCD&timeframe=30&sortBy=updated&bc=20

In California, Hawaii, Oregon, Washington, Colorado, Georgia, Maryland, Virginia, and the District of Columbia, Kaiser Permanente is an HMO plan with a Medicare contract. Colorado has a PPO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

Benefits, premium and/or copayments/coinsurance may change on January 1 of each year. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.