

(b) Make the decision available at the HHS Medicare Internet site. The posted decision does not include any information that identifies any individual, provider of service, or supplier.

**§ 426.550 Mandatory provisions of the Board's decision.**

(a) *Findings.* The Board's decision must include one of the following:

(1) A determination that the provision of the NCD is valid under the reasonableness standard.

(2) A determination that the provision of the NCD is not valid under the reasonableness standard.

(3) A statement dismissing the complaint regarding the NCD, and a rationale for the dismissal.

(4) A determination that the LCD or NCD record is complete and adequate to support the validity of the LCD or NCD provisions under the reasonableness standard.

(b) *Other information.* The Board's decision must include all of the following:

(1) The date of issuance.

(2) The docket number of the NCD review.

(3) A statement as to whether the aggrieved party has filed a claim for the service(s) named in the complaint, the date(s)-of-service, and the disposition, if known.

(4) A basis for concluding that the NCD was or was not valid based on the application of the reasonableness standard to the record before the Board, including CMS':

(i) Findings of fact.

(ii) Interpretations of law.

(iii) Applications of fact to law.

(5) A summary of the evidence reviewed. Where proprietary or privileged data were submitted under seal, the decision must state whether the data were material and what role they played in the determination, but without disclosing the substance or contents of the evidence under seal. A separate statement of the rationale for the Board's treatment of the sealed evidence must be prepared and kept under seal itself. If the Board decision is appealed to the court, this statement must be provided to the court, under seal.

(6) A statement regarding the right to judicial review.

**§ 426.555 Prohibited provisions of the Board's decision.**

The Board's decision may not do any of the following:

(a) Order CMS to add any language to a provision or provisions of an NCD.

(b) Order CMS or its contractors to pay a specific claim.

(c) Set a time limit for CMS to establish a new or revised NCD.

(d) Review or evaluate an NCD other than the NCD under review.

(e) Include a requirement for CMS or its contractors that specifies payment, coding, or systems changes for an NCD, or deadlines for implementing these types of changes.

(f) Order or address how CMS implements an NCD.

**§ 426.557 Optional provisions of the Board's decision.**

When appropriate, the Board may limit a decision holding invalid a specific provision(s) of an NCD to specific clinical indications and for similar conditions.

**§ 426.560 Effect of the Board's decision.**

(a) *Valid under the reasonableness standard.* If the Board finds that the provision (or provisions) of an NCD named in the complaint is (are) valid under the reasonableness standard, the aggrieved party may challenge the final agency action in Federal court.

(b) *Not valid under the reasonableness standard.* If the Board finds that the provision (or provisions) of an NCD named in the complaint is (are) invalid under the reasonableness standard, then CMS instructs its contractor, M + C organization, or other Medicare managed care organization to provide the following—

(1) *Individual claim review.* (i) If the aggrieved party's claim/appeal(s) was previously denied, the contractor, an M + C organization, or another Medicare managed care organization must reopen the claim of the party who challenged the LCD and adjudicate the claim without using the provision(s) of the NCD that the Board found invalid.