CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1580	**Date: December 3, 2015**
	Change Request 9252

Transmittal 1547, dated October 5, 2015, is being rescinded and replaced by Transmittal 1580, dated December 3, 2015, to: 1) remove invalid TOB 52X from NCD250.5, 2) remove invalid TOB 25X from and add TOB 85X to NCD80.11, and, 3) include complete history in NCD160.18. All other information remains the same.

SUBJECT: ICD-10 Conversion/Coding Infrastructure Revisions to National Coverage Determinations (NCDs)--3rd Maintenance CR

I. SUMMARY OF CHANGES: This change request (CR) is the 3rd maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CR7818, CR8109, CR8197, CR8691, & CR9087. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

EFFECTIVE DATE: October 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016 - Exceptions: FISS will implement the following NCDs April 4, 2016: 260.1, 80.11, 20.16, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, and 160.24. CWF will deactivate edits 33XA and 33#A (NCD150.3) prior to the January 2016 implementation date

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to both create and update national coverage determination (NCD) editing, both hard-coded shared system edits as well as local Medicare Administrative Contractor (MAC) edits, that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, POS/TOB/provider specialties, etc. The requirements described herein reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

B. Policy: This CR is the 3rd maintenance update of ICD-10 conversions/coding specific to NCDs. The majority of the NCDs included are a result of feedback received on previous ICD-10 NCD CR7818, CR8109, CR8197, CR8691, & CR9087. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding.

Edits to ICD-10 coding specific to NCDs will be included in subsequent quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

NOTE: As has historically been the case, NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. The 26 spreadsheets accessible via https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are designated as such and are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local Medicare Administrative Contractors may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

NOTE: Nothing contained in this CR should be construed as new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility

		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9252.1	The SSMs shall implement the edits/logic associated with the referenced NCDs using the attached Excel spreadsheets ONLY IF APPLICABLE.					X	X		X	
9252.2	A/B MACs shall complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR. NOTE: A/B MACs shall use default CAQH CORE messages where appropriate: RARC N386 with CARC 50, 96, and/or 119. See latest CAQH CORE update.	X	X							
9252.3	When denying claims associated with the attached NCDs, except where otherwise indicated, A/B MACs shall use: Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file). Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). NOTE: For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

9252.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Pat Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (CMS Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 26 – Refer to URL Section B. Policy