CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1753	**Date: November 17, 2016**
	Change Request 9751

Transmittal 1708, dated August 19, 2016, is being rescinded and replaced by Transmittal 1753, dated, November 17, 2016to: NCD180.1, change 7/1/16 effective date in spreadsheet history to 1/1/16, NCD160.18, remove reactivation of MCS 012L from spreadsheet history and business requirement, NCD220.6.20, remove reference to 'primary diagnosis' regarding diagnosis code Z00.6 in spreadsheet, reference FISS new RC for value code D4 in spreadsheet history. All other information remains the same.

SUBJECT: Coding Revisions to National Coverage Determination (NCDs)

I. SUMMARY OF CHANGES: This change request (CR) is the 9th maintenance update of ICD-10 conversions and other coding 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, CR9252, CR9540, and CR9631. Some are the result of revisions required to other NCD-related CRs released separately.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases 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: January 1, 2017 - Unless otherwise noted
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

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

Pub. 100-20	Transmittal: 1753	Date: November 17, 2016	Change Request: 9751

Transmittal 1708, dated August 19, 2016, is being rescinded and replaced by Transmittal 1753, dated, November 17, 2016to: NCD180.1, change 7/1/16 effective date in spreadsheet history to 1/1/16, NCD160.18, remove reactivation of MCS 012L from spreadsheet history and business requirement, NCD220.6.20, remove reference to 'primary diagnosis' regarding diagnosis code Z00.6 in spreadsheet, reference FISS new RC for value code D4 in spreadsheet history. All other information remains the same.

SUBJECT: Coding Revisions to National Coverage Determination (NCDs)

EFFECTIVE DATE: January 1, 2017 - Unless otherwise noted
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

I. GENERAL INFORMATION

A. Background: This change request (CR) is the 9th maintenance update of ICD-10 conversions and other coding 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, CR9252, CR9540, and CR9631. Some are the result of revisions required to other NCD-related CRs released separately.

B. Policy: Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases 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. Please follow the link below for the NCD spreadsheets included with this CR:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9751.zip

CLARIFICATION: Coding (as well as payment) are separate and distinct areas of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

NOTE: The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete GEMS mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow Medicare Administrative Contractor discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

NOTE/CLARIFICATION: A/B MACs shall complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

NOTE/CLARIFICATION: 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. 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). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.

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	
9751.1	NCD260.1 Adult Liver Transplants Contractors shall update their local edits and shared edits to reflect the additional diagnoses codes in the spreadsheet categorized as nationally covered, nationally non-covered, and discretionary effective 10/1/15. FISS will develop a new reason code to replace local edits to assign when one of the discretionary diagnosis codes are present. Consistency edit RC 32918 will be modified to remove dx check and check for provider liver transplant certification when procedure codes approved for liver transplants are present. MCS will revise edits to assign when discretionary codes are present. Contractors shall ensure that FISS RCs 59101, 59102, 32918, MCS edit 026L are reactivated effective with implementation of this CR9751.	X	X			X	X			
9751.2	NCD190.3 Cytogenetic Studies Contractors shall update their local and shared edits to include the additional discretionary diagnoses codes in the spreadsheet effective 10/1/15. FISS will develop a new reason code to replace local edits to assign when one of the discretionary diagnosis codes are present. MCS will revise edits to assign when discretionary codes are present.	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractors shall ensure that FISS RCs 59154, 59155, and MCS edit 044L are reactivated effective with implementation of this CR9751.									
9751.3	NCD220.6.20 PET Beta Amyloid in Dementia/Neurological/ Disorders Contractors shall update edits to remove HCPCS codes C9458 and C9459 from NCD policy effective 6/30/16 as reflected in the spreadsheet. Contractors shall add Q9982 and Q9983 effective 7/1/16 as reflected in the spreadsheet. MCS edit 010K & 011K CWF shall add 1x per lifetime frequency to Q9982 and Q9983 effective 7/1/16. Contractors shall update CARC/RARC messages as indicated in spreadsheet to adhere to CORE.	X	X			X	X		X	
9751.4	NCD20.19 Ambulatory Blood Pressure Monitoring (ABPM) Contractors shall be aware that POS 22 Outpatient Hospital has been added to the policy as reflected in the spreadsheet. Contractors shall be aware that POS 19 Outpatient Hospital Off-Campus has been added to the policy as reflected in the spreadsheet. Contractors shall be aware that TOB 14X Outpatient Hospital Non-Patient has been deleted from the policy as reflected in the spreadsheet. MCS edit 218D, FISS RCs 59005-59008.	X	X			X	X			
9751.5	NCD220.6.17 FDG PET for Solid Tumors Contractors shall add to their local edits new HCPCS C9461, Choline C-11, diagnostic, per study, to this policy effective 4/1/16. The edits shall mirror those for HCPCS A9552 effective 6/11/13 in CR8739. See 8739-04.4.1, 8739-04.5, 8739-04.6, 8739-04.6.1, 8739-04.6.2, 8739-04.6.3.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	Contractors shall update CARC/RARC messages as indicated in spreadsheet to adhere to CORE.									
9751.6	NCD20.33 Transcatheter Mitral Valve Repair (TMVR) Therapy Contractors shall add to their local and shared edits 10 new 2017 PCS codes effective 10/1/16. Contractors shall update CARC/RARC messages as indicated in spreadsheet to adhere to CORE.	X				X				
9751.7	NCD20.7 Percutaneous Transluminal Angioplasty (PTA) Contractors shall add to their local and shared edits 210 new 2017 PCS codes effective 10/1/16 as reflected in the spreadsheet. Contractors shall be aware that 51 procedure codes were removed from the policy effective 10/1/15 with CR9631.	X				X				
9751.8	NCD180.1 Medical Nutrition Therapy (MNT) Contractors shall remove HCPCS G0108, G0109 from local and shared edits FISS RCs 59148 & 59149, MCS edit 038L effective 1/1/16 as reflected in the spreadsheet. Contractors shall reactivate FISS RCs 59148 & 59149, MCS edit 038L effective with implementation of this CR9751.	X	X			X	X			
9751.9	NCD40.1 Diabetes Self-Management Training (DSMT) Contractors shall revise their messaging to comply with CORE as reflected in the spreadsheet. Contractors shall remove 18 diagnoses codes from their local and shared edits as reflected in the spreadsheet effective 1/1/17 (R73.09, Z71.3, Z86.32, E83.110, E83.39, NOC codes O24.911, O24.912, O24.913, O24.919, O24.93, O24.311, O24.312, O24.313, O24.319, O24.33, P70.0, P70.1, P70.2) . MCS edit 038L, FISS RCs 59126, 59127, 59128,	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	59129, 59130, 59131, 59132, 59133.									
9751.10	NCD230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence Contractors shall remove CPT codes 95974 and 95975 (cranial nerves) from local edits and NCD as reflected in spreadsheet effective 10/1/15. Contractors shall update CARC/RARC messages as indicated in spreadsheet to adhere to CORE.	X								
9751.11	NCD160.18 Vagus Nerve Stimulation (VNS) Contractors shall ensure that HCPCS programming codes 95970, 95971, 95978, 95979, and CPT 61867, 61868, 61886, 61888, 64553 are removed from FISS RCs 59039, 59040, 59041, 59042, 59043, 59044, MCS edit 012L effective 7/1/16 per instructions in CR9540 and as reflected in spreadsheets. Contractors shall ensure that FISS RCs 59039, 59040, 59041, 59042, 59043, 59044 are reactivated with the implementation of this CR9751.	X	X			X	X			
9751.12	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. 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). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148.	X	X							
9751.13	Contractors shall attend up to three 1-hour calls to conduct analysis and explore options to implement the outstanding edits associated with CR9403 HIV	X	X			X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	screening. The scheduling of the calls will occur after the CR has been Issued.									
9751.14	Contractors shall adjust any claims processed in error associated with CR9751 that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9751.15	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 (Coverage) , Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (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: 11