DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Revised product from the Medicare Learning Network®

- **"Medicare Claim Review Programs"** Booklet, (ICN 006973) Downloadable

MLN Matters® Number: MM9252 Revised	**Related Change Request (CR) #: CR 9252**
Related CR Release Date: December 3, 2015	**Effective Date: October 1, 2015**
Related CR Transmittal #: R1580OTN	**Implementation Date: January 4, 2016,** **Exceptions: FISS will implement the following NCDs: April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, 160.24**

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

Note: This article was revised on December 3, 2015, to reflect an updated CR that: 1) Removed invalid TOB 52X from NCD250.5; 2) Removed invalid TOB 25X from NCD80.11 and added TOB 85X; and 3) Included complete history in NCD160.18. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What you Need to Know

Change Request (CR) 9252 is the third 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 CRs, Specifically, they were contained in CR7818, CR8109, CR8197, CR8691, and CR9087. Related MLN Matters® Articles are **MM7818**, **MM8109**, **MM8197**, **MM8691**, and **MM9087**. 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.

Background

CR9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, and so forth. The requirements described in CR9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at **https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip** on the Centers for Medicare & Medicaid (CMS) website.

NCD policies may contain specific covered, non-covered and/or discretionary diagnosis and procedure coding. These 26 spreadsheets are designated as such and are based on current NCD policies and their corresponding edits.

You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

Some coding details are as follows:

1. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
    - Remittance Advice Remark Code (RARC) N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with
    - Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer),
    - CARC 96 (Non-covered charge(s). At least one Remark Code must be provided [may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT]), and/or

- CARC 119 (Benefit maximum for this time period or occurrence has been reached).

2. When denying claims associated with the NCDs in the 26 spreadsheets, except where otherwise indicated, your MACs will use:

   - Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an Advance Beneficiary Notice (ABN) to the patient), 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 (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file)
   - For modifier GZ, your MAC will use CARC 50.

Additional Information

The official instruction, CR9252, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1580OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

Document History

Date	Description
December 3, 2015	Article was revised to reflect new CR that: 1) Removed invalid TOB 52X from NCD250.5, 2) Removed invalid TOB 25X from NCD80.11 and added TOB 85X and, 3) Included complete history in NCD160.18.
October 6, 2015	Article was revised to reflect new CR issued on October 5, 2015. In the article, the CR release date, transmittal number, and the Web address for accessing CR9252 are revised.