

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-20 One-Time Notification</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 12626</b>	<b>Date: May 9, 2024</b>
	<b>Change Request 13596</b>

**SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--October 2024**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to provide a quarterly maintenance update of ICD-10 coding conversions and other coding updates specific to National Coverage Determinations (NCDs). No policy is being changed as a result of these updates.

**EFFECTIVE DATE: As indicated in individual BRs**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: June 10, 2024 - BRs 2, 3 and 1 (0448U only); July 1, 2024 - BR 1 (0473U only)**

*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/revise 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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
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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**SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--October 2024**

**EFFECTIVE DATE: As indicated in individual BRs**

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**IMPLEMENTATION DATE: June 10, 2024 - BRs 2, 3 and 1 (0448U only); July 1, 2024 - BR 1 (0473U only)**

## I. GENERAL INFORMATION

**A. Background:** The purpose of this Change Request (CR) is to provide a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at:

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process.

**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/CR13596.zip>

Clarification: Coding (as well as payment) is a separate and distinct area 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 one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs)\* mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. \*GEMs mapping is no longer provided by CMS as of October 1, 2019. In addition, for those policies that expressly allow Medicare Administrative Contractor (MAC) 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 Part A and A/B MACs Part B 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 Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (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 Advance Beneficiary Notice (ABN) is on file). Group Code CO



Number	Requirement	Responsibility									
		A/B MAC		D M E	Shared- System Maintainers				Other		
		A	B		H H H	M A C	F I S S	M C S		V M S	C W F
13596.4	Contractors shall not search claims, but shall adjust claims brought to their attention.	X	X								

**III. PROVIDER EDUCATION TABLE**

Number	Requirement	Responsibility						
		A/B MAC			D M E	C E D I		
		A	B	H H H			M A C	
13596.5	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	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**

**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: 3**