CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1478	Date: March 6, 2015
	Change Request 9087

SUBJECT: ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs)--2nd Maintenance CR

I. SUMMARY OF CHANGES:
This change request (CR) is the second maintenance update of ICD-10 conversions and ICD-9 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, and CR8691. Some are the result of revisions required to other NCD-related CRs released separately that also 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 recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

EFFECTIVE DATE: April 6, 2015 - For designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015 - For all ICD-9 shared system edits; October 1, 2015 - For all ICD-10 shared system edits (or whenever ICD-10 is implemented)
Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: April 6, 2015 - For designated ICD-9 updates and all local system edits; July 6, 2015 - For ICD-9 and ICD-10 shared system edits

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: 0

One Time Notification

Attachment - One-Time Notification

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IMPLEMENTATION DATE: April 6, 2015 - For designated ICD-9 updates and all local system edits; July 6, 2015 - For ICD-9 and ICD-10 shared system edits

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 either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, 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 second maintenance update of ICD-10 conversions/ICD-9 coding specific to NCDs. The majority of the NCDs included are a result of feedback received on previous ICD-10 NCD CR7818, CR8109, CR8197, and CR8691. Some are the result of revisions required to other NCD-related CRs released separately that also 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 recurring 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 attached spreadsheets 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 NCD reconsideration. Discretionary code lists 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. 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	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		
9087.1	The SSMs shall implement the edits/logic associated with the referenced NCDs using the attached Excel spreadsheets ONLY IF APPLICABLE.					X	X		X		
9087.2	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								
9087.3	The SSMs shall ensure the ICD-10 diagnosis/procedure codes associated with the attached NCDs are not implemented until October 1, 2015, or until ICD-10 is implemented.					X	X		X		
9087.4	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			D M E M A C	C E D I
		A	B	H H H		
9087.5	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"	X	X			

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

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: 10