CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11264	**Date: February 10, 2022**
	Change Request 12606

SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) -- July 2022

I. SUMMARY OF CHANGES: This Change Request (CR) constitutes 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.

EFFECTIVE DATE: July 1, 2022 - unless otherwise specified in individual requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 2022 - A/B MACs; July 5, 2022 - Shared Systems

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: 11264	Date: February 10, 2022	Change Request: 12606

SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) -- July 2022

EFFECTIVE DATE: July 1, 2022 - unless otherwise specified in individual requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 2022 - A/B MACs; July 5, 2022 - Shared Systems

I. GENERAL INFORMATION

A. Background: This Change Request (CR) constitutes 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 NCD policy.

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/CR12606.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 (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 Medicare Summary

Notice (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	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12606.1	NCD 20.4 Implantable Cardiac Defibrillators (ICDs) Contractors shall be aware that the descriptor has been corrected for 7 ICD-10 diagnosis codes noted on the procedure tab, and 1 incorrect descriptor on the diagnosis tab of the spreadsheet. See spreadsheet.	X	X							
12606.2	NCD 160.18 Vagus Nerve Stimulation (VNS) Contractors shall end-date the bypass logic for 64568 and 0466T effective December 31, 2021. No bypass logic is needed effective January 1, 2022, forward. See attached spreadsheet.	X	X			X	X			
12606.3	NCD 190.1 Histocompatibility Testing Contractors shall be aware that the spreadsheet is revised to remove diagnosis codes from column B of Rule Description. No action necessary. See spreadsheet.	X	X							
12606.4	NCD 30.3.3 Acupuncture for Chronic Low Back Pain For dates of service on or after January 21, 2020, with claims received on or after July 5, 2022, CWF shall create a new reject to validate the incoming claim when the allowed add-					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	on code 97811 is billed and the initial code 97810 is present for the same date of service and is denied, OR, The allowed add-on code 97814 is billed and the initial code 97813 is present for the same date of service and is denied. CWF shall return the new error code identifying the detail line subject to the reject in Trailer 08. NOTE: CWF shall allow initial code 97810 or 97813 without add-on code. See spreadsheet.									
12606.4.1	NCD 30.3.3 Acupuncture for Chronic Low Back Pain For dates of service on or after January 21, 2020, with claims received on or after July 5, 2022, CWF shall create a new reject to ensure if an allowed add on-code 97811 is billed that the initial code 97810 is either posted on the Beneficiary's ACUP Auxiliary File for the same date of service or present on the incoming claim, OR, The allowed add-on code 97814 is billed and the initial code 97813 is either posted on the Beneficiary's ACUP Auxiliary File for the same date of service or present on the incoming claim. CWF shall return the new error code identifying the detail line subject to the reject in Trailer 39/43.					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	NOTE: CWF can carry multiple add-on codes for same Date of Service. See spreadsheet.									
12606.4.2	NCD 30.3.3 Acupuncture for Chronic Low Back Pain For dates of service on or after January 21, 2020, with claims received on or after July 5, 2022, CWF shall create a new reject to ensure codes 20560 and 20561 are not billed on the same Date of Service. CWF shall read both the Beneficiary's ACUP Auxiliary File for the same Dates of Service or the incoming claim for the reject. CWF shall return the new error code identifying the detail line subject to the reject in Trailer 39/43. See attached spreadsheet.					X			X	
12606.5	NCD 150.3 Bone Mineral Density Studies Contractors shall be aware that the spreadsheet is revised to clarify no copayment/deductible waiver should be attached to HCPCS 0554T-0558T, effective July 1, 2019. NOTE: Based on the USPSTF recommendation Grade B, only central dual-energy x-ray absorptiometry (DXA), peripheral DXA, and quantitative ultrasound (QUS) are specifically listed so only these should be included in the preventive service tool and eligible for the waiver.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	See spreadsheet.									
12606.6	Contractors shall adjust any claims processed in error associated with this CR that are brought to their attention.	X	X							
12606.7	Contractors shall use default CAQH CORE messages where appropriate when denying claims associated with the attached NCDs, except where otherwise indicated: RARC N386 with CARC 50, 96, and/or 119. See latest CAQH CORE update. Group Code PR 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 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							
12606.8	Contractors shall ATTEND up to two 1-hour calls to conduct analysis and explore options to implement outstanding edit issues for the July 2022 release as they pertain to ICD-10 and NCDs. The scheduling of the calls will occur after this CR has been issued ONLY IF NEEDED.	X	X			X	X		X	
12606.9	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.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12606.10	NCD 110.24 CAR T-Cell Therapy FISS shall ensure that FISS RC 32979 allows TOB 85X with revenue code 0891 when billed with HCPCS C9399 for claims with DOS on and after 8/7/19. See attached spreadsheet.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12606.11	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	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): Wanda Belle, 410-786-1149 or wanda.belle@cms.hhs.gov (Coverage) , Pat Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Coverage)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: Refer to Section B.