CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11460	**Date: June 17, 2022**
	Change Request 12705

Transmittal 11400, dated May 4, 2022, is being rescinded and replaced by Transmittal 11460, dated, June 17, 2022, to update NCD 90.2, NGS, spreadsheet to conform with changes in CR 12124, and change the implementation date for all business requirements except 12705.6 to 30 days from issuance of this correction. All other information remains the same.

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

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.

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.

EFFECTIVE DATE: October 1, 2022 - Or as indicated in individual business requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 19, 2022 - A/B MACs, for all business requirements except 12705.6; October 3, 2022 - SSMs, business requirement 12705.6 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/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: 11460	Date: June 17, 2022	Change Request: 12705

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

EFFECTIVE DATE: October 1, 2022 - Or as indicated in individual business requirements
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I. GENERAL INFORMATION

A. Background: This 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/CR12705.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 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	
12705.1	NCD 20.31 Intensive Cardiac Rehabilitation Informational formatting changes only no action needed. See NCD spreadsheet.	X	X							
12705.2	NCD 20.31.1 Intensive Cardiac Rehabilitation - Pritkin Program Informational formatting changes only no action needed. See NCD spreadsheet.	X	X							
12705.3	NCD 20.31.2 Intensive Cardiac Rehabilitation - Ornish Program Add ICD-10 I50.22 removed in error in CR 12480. Informational formatting changes also no action needed. See NCD spreadsheet.	X	X							
12705.4	NCD 20.31.3 - Intensive Cardiac Rehabilitation - Benson-Henry Program Informational formatting changes also no action needed. See NCD spreadsheet.	X	X							
12705.5	NCD 90.2 Next Generation Sequencing (NGS)	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Add ICD-10 diagnoses C22.0, C22.1 to CPT 0022U due to descriptor change effective April 1, 2022. See NCD spreadsheet.									
12705.6	NCD 160.18 Vagus Nerve Stimulation FISS to modify RCs 59039/59040 to NOT assign when either CPT 95976 or 95977 are billed and either ICD-10 diagnosis G47.33 OR Z45.42 appear on a claim, effective for dates of service on or after January 1, 2019. MCS to modify edit 012L to NOT assign when CPT when either CPT 95976 or 95977 are billed and either ICD-10 diagnosis G47.33 OR Z45.42 appear on a claim, effective for dates of service on or after January 1, 2019. See NCD spreadsheet.	X	X			X	X			
12705.7	NCD 180.1 Medical Nutrition Therapy Informational updated spreadsheet to align with CR 12613 and CR 12027. No action necessary. ICD-10 dx N18.31 remove GFR <51 effective January 1, 2022 (aligns with CR 12027). Effective January 1, 2022, remove the word "treating" in describing physician in the NCD. (aligns with CR 12613). See NCD spreadsheet.	X	X							
12705.8	NCD 270.3 Autologous Blood-Derived Products for Chronic	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Non-Healing Wounds Add ICD-10 diagnosis codes coverable effective April 13, 2021. ICD-10 diagnosis L97.311-L97.314, L97.511-L97.516, L97.518, L97.521-L97.526, L97.528, L97.812-L97.816, L97.818, L97.821-L97.826, L97.828, L98.495-L98.496, L98.498. NOTE: Clarifying that deletion of ICD-10 diagnosis L98.491-L98.499 from CR 10318 effective 10/1/15 applied to previous Group 2. See attached spreadsheet.									
12705.9	Contractors shall adjust any claims processed in error associated with this CR that are brought to their attention.	X	X							
12705.10	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. Along with: 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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
12705.11	Contractors shall ATTEND one 1-hour call AS NECESSARY to conduct analysis and explore options to implement outstanding edit issues for the October 2022 release as they pertain to ICD-10 and NCDs. The scheduling of the calls will occur after this CR has been issued.	X	X			X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12705.12	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): 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):
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: Refer to Section B.