| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-20 One-Time Notification | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 12757** | **Date: August 2, 2024** |
| | **Change Request 13706** |

**SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) and Update to the Appropriate Use Criteria (AUC) Program--January 2025**

**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) and to provide an update to the Appropriate Use Criteria (AUC) Program. No policy is being changed as a result of these updates.

**EFFECTIVE DATE: January 1, 2025 - See BR 2 & 3 different effective dates**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 6, 2025**

***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

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## II. GENERAL INFORMATION

**A. Background:** The purpose of this Change Request (CR) is to provide a maintenance update of ICD10 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.

We are also utilizing this CR to remove the delayed termination of the Appropriate Use Criteria (AUC) Program modifiers. We delayed the removal of these modifiers by one year following the AUC pause effective January 1, 2024, as indicated in CR 13485. The effective date of the modifier removal is January 1, 2025.

**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/CR13706.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.

## III. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 13706.1 | NCD 20.33 TMVR/TEER<br><br>Contractors shall delete any existing edits that require ICD-10 diagnoses I34.0 and I34.1 be listed as primary, along with clinical trial ICD-10 diagnosis Z00.6 as secondary, on NCD 20.33 claims with dates of service on and after January 1, 2025. This includes FISS reason code 59266 and MCS edit 073L. This change only pertains to the deletion of primary/secondary verbiage as these codes can be reported in any position.<br><br>See attached spreadsheet. | X | X | | | X | X | | | |
| 13706.2 | NCD 210.10 STIs<br><br>Contractors shall add CPT 0455U effective July 1, 2024.<br><br>Contractors shall end-date CPT 0353U effective June 30, 2024.<br><br>This includes MCS edit 079D/169D, FISS RC 59170-59171. | X | X | | | X | X | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | See attached spreadsheet. | | | | | | | | | |
| 13706.3 | AUC Program<br><br>Contractors shall end-date the following 30 modifiers, CPT/HCPCS codes associated with the AUC Program effective December 31, 2024. See initial AUC CR 13485.<br><br>MA, MB, MC, MD, ME, MF, MG, MH, QQ, G1001, G1002, G1003, G1004, G1007, G1008, G1010, G1011, G1012, G1013, G1014, G1015, G1016, G1017, G1018, G1019, G1020, G1021, G1022, G1023, G1024. | X | X | | | | | | | |
| 13706.4 | Contractors shall not search claims but shall adjust claims that are brought to their attention. | X | X | | | | | | | |

## IV. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 13706.5 | 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 | | | |

## V. 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

**VI. CONTACTS**

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

**VII. FUNDING**

**Section A: For Medicare Administrative Contractors (MACs):**
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**ATTACHMENTS: 2**