CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2202	**Date: November 9, 2018**
	Change Request 11005

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

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, long-standing NCD process.

EFFECTIVE DATE: April 1, 2019 - Unless otherwise noted in requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019 - for SSMs, for local MACs 60 days from issuance of CR

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: 2202	Date: November 9, 2018	Change Request: 11005

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

EFFECTIVE DATE: April 1, 2019 - Unless otherwise noted in requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019 - for SSMs, for local MACs 60 days from issuance of CR

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/CR11005.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. 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11005.1	NCD20.7 Percutaneous Transluminal Angioplasty (PTA) Contractors shall add ICD-10 dx I63.031, I63.032, I63.033, I63.131, I63.132, I63.133, I63.233 to covered dx codes effective October 1, 2015. Contractors shall end-date ICD-10 dx I66.9, I66.09, I66.19, I66.29 Not Otherwise Classified (NOC) codes effective April 1, 2019. See spreadsheet	X	X			X	X			
11005.2	NCD110.21, Erythropoiesis Stimulating Agents (ESAs) in Cancer and Neoplastic Conditions FISS shall implement edits to RC59274-59275 from CR10859 to remove ICD-10 D61.1 from non-covered list effective January 1, 2017. FISS shall implement RCs59276-59277 to assign when dx are not present. MCS shall implement edit updates to 292D from CR10859 to remove ICD-10 D61.1 from non-covered list effective January 1, 2017. MACs shall update their local/discretionary edits for DOS January 1, 2017 - September 30, 2017, to cover some of the FISS RC edits that will not assign until October 1, 2017. MACs shall remove any workarounds implemented as a result of this delayed shared edit upon implementation of the above.	X	X			X	X			
11005.3	NCD210.2 Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancers Contractors shall take note of updated policy verbiage	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	regarding frequency and install any edits not already installed effective October 1, 2015. FISS shall create new 59CXX RCs to allow denial of CWF RCs 5612/5616 when frequency has been exceeded. MACs shall either manually or with ECPS apply new 59CXX RCs when CWF edit is received to ensure benefit savings are properly captured. Denial messages are as follows: CARC 119, RARC M83 or N362, MSN 18.17, CO and PR as appropriate. See spreadsheet.									
11005.4	NCD220.4 Mammograms Contractors shall add ICD-10 dx N63.10, N63.20 to covered dx list effective October 1, 2018. Note: Dual dx codes depicting specific quadrants can be reported instead of unspecified quadrants if found more appropriate by provider. See spreadsheet.	X	X			X	X			
11005.5	NCD230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence Contractors shall end-date CPT supply codes C1767, C1778, C1883, C1897 from shared edits effective April 1, 2019. (Removed from line 9) Contractors (A/MACs) shall ensure CPT supply codes C1767, C1778, C1883, C1897 remain in local edits for contractor discretion. See spreadsheet.	X								
11005.6	Contractors shall adjust any claims processed in error associated with CR11005 that are brought to their attention.	X	X							
11005.7	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	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	119. See latest CAQH CORE update.									
11005.7.1	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). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148. NOTE: This replicates the note under the Policy section.	X	X							
11005.8	NCD80.11 Vitrectomy MCS shall implement update from CR10859 to delete ICD-10 dx H35.53 and add ICD-10 dx H35.52 effective January 1, 2019. MACs shall remove any workarounds implemented as a result of this delayed shared edit upon implementation of the above. See spreadsheet.	X	X				X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11005.9	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

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: 6

NCD:	110.21		
NCD Title:	Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions		
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322&ncdver=1		
		ICD-10 CM	**ICD-10 DX Description**
Standard systems maintainers (SSMs) shall DENY non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier -EC (ESA, anemia, non-chemo/radio) when any one of the following diagnosis codes is present on the claim			
		C92.00	Acute myeloblastic leukemia, not having achieved remission
		C92.40	Acute promyelocytic leukemia, not having achieved remission
		C92.50	Acute myelomonocytic leukemia, not having achieved remission
		C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
		C92.A0	Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
		C92.01	Acute myeloblastic leukemia, in remission
		C92.41	Acute promyelocytic leukemia, in remission
		C92.51	Acute myelomonocytic leukemia, in remission
		C92.61	Acute myeloid leukemia with 11q23-abnormality in remission
		C92.A1	Acute myeloid leukemia with multilineage dysplasia, in remission
		C92.02	Acute myeloblastic leukemia, in relapse
		C92.42	Acute promyelocytic leukemia, in relapse
		C92.52	Acute myelomonocytic leukemia, in relapse
		C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
		C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
		C92.10	Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission
		C92.11	Chronic myeloid leukemia, BCR/ABL-positive, in remission
		C92.12	Chronic myeloid leukemia, BCR/ABL-positive, in relapse
		C92.20	Atypical chronic myeloid leukemia, BCR/ABL-negative, not having achieved remission
		C92.21	Atypical chronic myeloid leukemia, BCR/ABL-negative, in remission
		C92.Z0	Other myeloid leukemia not having achieved remission
		C92.Z1	Other myeloid leukemia, in remission
		C92.Z2	Other myeloid leukemia, in relapse
		C92.90	Myeloid leukemia, unspecified, not having achieved remission
		C92.91	Myeloid leukemia, unspecified in remission
		C94.00	Acute erythroid leukemia, not having achieved remission
		C94.01	Acute erythroid leukemia, in remission
		C94.02	Acute erythroid leukemia, in relapse
		C94.20	Acute megakaryoblastic leukemia not having achieved remission
		C94.21	Acute megakaryoblastic leukemia, in remission
		C94.22	Acute megakaryoblastic leukemia, in relapse
		C94.30	Mast cell leukemia not having achieved remission
		C94.80	Other specified leukemias not having achieved remission
		C94.31	Mast cell leukemia, in remission
		C94.81	Other specified leukemias, in remission
		D45	Polycythemia vera

		ICD-10 CM	ICD-10 DX Description
		D50.0	Iron deficiency anemia secondary to blood loss (chronic)
		D50.8	Other iron deficiency anemias
		D50.1	Sideropenic dysphagia
		D50.9	Iron deficiency anemia, unspecified
		D51.0	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
		D51.1	Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria
		D51.2	Transcobalamin II deficiency
		D51.3	Other dietary vitamin B12 deficiency anemia
		D51.8	Other vitamin B12 deficiency anemias
		D51.9	Vitamin B12 deficiency anemia, unspecified
		D52.0	Dietary folate deficiency anemia
		D52.1	Drug-induced folate deficiency anemia
		D52.8	Other folate deficiency anemias
		D52.9	Folate deficiency anemia, unspecified
		D53.1	Other megaloblastic anemias, not elsewhere classified
		D58.0	Hereditary spherocytosis
		D55.0	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency
		D55.1	Anemia due to other disorders of glutathione metabolism
		D58.9	Hereditary hemolytic anemia, unspecified
		D59.0	Drug-induced autoimmune hemolytic anemia
		D59.1	Other autoimmune hemolytic anemias
		D59.4	Other nonautoimmune hemolytic anemias
		D59.2	Drug-induced nonautoimmune hemolytic anemia
		D59.5	Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]
		D59.6	Hemoglobinuria due to hemolysis from other external causes
		D59.8	Other acquired hemolytic anemias
		D59.9	Acquired hemolytic anemia, unspecified
		D60.0	Chronic acquired pure red cell aplasia
		D60.1	Transient acquired pure red cell aplasia
		D60.8	Other acquired pure red cell aplasias
		D60.9	Acquired pure red cell aplasia, unspecified
		D61.01	Constitutional (pure) red blood aplasia
		D61.09	Other constitutional aplastic anemia
		D61.2	Aplastic anemia due to other external agents
		D61.3	Idiopathic aplastic anemia
		D61.810	Antineoplastic chemotherapy induced pancytopenia
		D61.811	Other drug-induced pancytopenia
		D61.818	Other pancytopenia
		D61.82	Myelophthisis
		D61.89	Other specified aplastic anemias and other bone marrow failure syndromes
		D61.9	Aplastic anemia, unspecified
		D62	Acute posthemorrhagic anemia
		D63.0	Anemia in neoplastic disease
		D64.0	Hereditary sideroblastic anemia
		D64.1	Secondary sideroblastic anemia due to disease
		D64.2	Secondary sideroblastic anemia due to drugs and toxins
		D64.3	Other sideroblastic anemias
		D64.9	Anemia, unspecified
		D73.1	Hypersplenism
		E53.1	Pyrioxine deficiency
		T45.1X5A	Adverse effect of antineoplastic and immunosuppresive drugs, initial encounter

NCD:	110.21		
NCD Title:	Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions		
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322&ncdver=1		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	N/A

NCD:	110.21 (CR9252, CR10318, CR10473, CR10859, CR11005)
NCD Title:	Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322&ncdver=1

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	Effective 7/30/07, non-ESRD ESA services are **covered** for anemia secondary to myelosuppressive anti-cancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions. Non-ESRD ESA services are **non-covered** for beneficiaries with certain clinical conditions.									
Part A	**A/MACS & FISS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EC** (ESA, anemia, non-chemo/radio) when any one of the specified non-covered diagnosis codes is present on the claim. See tab ICD Diagnosis for this list.	J0881 J0885	N/A	N/A	NA	EC	NA	15.20	50	N386
Part A	**FISS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EB** (ESA, anemia, radio-induced) regardless of dx no discretion allowed.	J0881 J0885	N/A	N/A	NA	EB	NA	15.20	50	N386
Part A	**A/MAC**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EA** (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.	J0881 J0885	N/A	N/A	NA	EA	NA	15.20	50	N386
Part A	**A/MAC: Effective 1/1/08, h**ave discretion to cover or non-cover non-ESRD ESA services (J0881/J0885) for any other: (1) non-radio/non-chemo-induced anemias with modifier -EC, (2) non-chemo-induced anemias with modifier -EA, not specifically addressed in NCD110.21.	J0881 J0885								

NCD:	110.21 (CR9252, CR10318, CR10473, CR10859, CR11005)									
NCD Title:	Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322&ncdver=1									
Part B	**Rule Description Part B**	**Proposed HCPCS/CPT Part B**	**Frequency Limitations**	**POS (Part B)**	**n/a**	**Modifier Part B**	**Provider Specialty**	**Proposed MSN Message Part B**	**Proposed CARC Message Part B**	**Proposed RARC Message Part B**
Part B	Effective 7/30/07, non-ESRD ESA services are **covered** for anemia secondary to myelosuppressive anti-cancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions. Non-ESRD ESA services are **non-covered** for beneficiaries with certain clinical conditions.									
Part B	**B/MAC/MCS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier -EC (ESA, anemia, non-chemo/radio) when any one of the specified non-covered diagnosis codes is present on the claim. See tab ICD Diagnosis for this list.	J0881 J0885	N/A	N/A	NA	EC	NA	15.20	50	N386
Part B	**MCS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier -EB (ESA, anemia, radio-induced) regardless of dx no discretion allowed.	J0881 J0885	N/A	N/A	NA	EB	NA	15.20	50	N386
Part B	**B/MAC**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier -EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anti-cancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.	J0881 J0885	N/A	N/A	NA	EA	NA	15.20	50	N386
Part B	B/MAC: Effective 1/1/08, have discretion to cover or non-cover non-ESRD ESA services (J0881/J0885) for any other: (1) non-radio/non-chemo-induced anemias with modifier -EC aside from the 10 indications specifically non-covered, (2) non-chemo-induced anemias with modifier -EA, not specifically addressed in NCD110.21, aside from the 3 indications specifically non-covered.	J0881 J0885								
	Revision History									
	CR9252: Clarify the listed dx codes are ALL non-covered when billed with modifer -EC and all other -EC dx discretionary. modifier -EB is always non-covered regardless of dx. modifier -EA is discretionary if not specifically addressed in NCD. RARC codes, reformat to current standard.								Clarify Clarify Add MSN,CARC,	
	Per First Coast, FISS RCs 59031/59032 can be removed because they are not needed and are incorrect. FISS RCs 32144/32146 suffice. TDL to follow.									
	CR10318: Add ICD-10 dx D46.1, D51.0, D60.0, D60.1, D60.8, D60.9, D61.0, D61.1, D61.2, D61.3, D61.01, D61.09, D61.81, D61.810, D61.811, D61.818, D61.82, D61.89, D61.9, D64.0, D64.1, D64.2, D64.3, D64.9, D63.8, D63.0, D63.1, D73.1, E53.1, T45.1X5A to non-covered dx list effective 1/1/17. (MCS 292D)									
	CR10473: Delete invalid ICD-10 dx D61.0, D61.81 effective 10/1/15. FISS to end-date non-NCD RCs, create new NCD RCs effective 10/1/17.									
	CR10859: Delete ICD-10 dx codes D46.1, D61.1, D63.1, and D63.8 from the non-covered dx code list effective 1/1/17. A/MACs set to suspend FISS RCs 59274-59275. Add ECPS event if volume of claims warrant. A/MACs to ensure ECPS events set up for FISS RCs 59276-59277. B/MACs set to suspend MCS edit 292D. Set-up SCF rules to automate if volume of claims warrant. FISS to modify NCD and non-NCD RCs used for this policy to utilize the correct dx coding. shall reactivate edits from CR10318, CR10473 with the implementation of this CR once the above edits are implemented. Reactivate the deactivated edits from CR10318, CR10473, with the implementation of this CR.									Contractors

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

		ICD-10 CM	ICD-10 DX Description
			CMS reserves the right to add or remove diagnosis codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy.
		E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
		E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
		E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
		E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
		E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
		E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
		E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
		E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
		E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
		E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
		E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and
		E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and
		E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
		E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
		E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
		E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
		E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
		E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
		E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
		E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
		E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
		E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
		E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
		E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
		E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
		E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and
		E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
		E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
		E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.36	Type 1 diabetes mellitus with diabetic cataract
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.36	Other specified diabetes mellitus with diabetic cataract
H16.241	Ophthalmia nodosa, right eye
H16.242	Ophthalmia nodosa, left eye
H16.243	Ophthalmia nodosa, bilateral
H20.11	Chronic iridocyclitis, right eye
H20.12	Chronic iridocyclitis, left eye
H20.13	Chronic iridocyclitis, bilateral
H20.21	Lens-induced iridocyclitis, right eye
H20.22	Lens-induced iridocyclitis, left eye
H20.23	Lens-induced iridocyclitis, bilateral
H20.821	Vogt-Koyanagi syndrome, right eye
H20.822	Vogt-Koyanagi syndrome, left eye
H20.823	Vogt-Koyanagi syndrome, bilateral

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
H25.011	Cortical age-related cataract, right eye
H25.012	Cortical age-related cataract, left eye
H25.013	Cortical age-related cataract, bilateral
H25.031	Anterior subcapsular polar age-related cataract, right eye
H25.032	Anterior subcapsular polar age-related cataract, left eye
H25.033	Anterior subcapsular polar age-related cataract, bilateral
H25.041	Posterior subcapsular polar age-related cataract, right eye
H25.042	Posterior subcapsular polar age-related cataract, left eye
H25.043	Posterior subcapsular polar age-related cataract, bilateral
H25.21	Age-related cataract, morgagnian type, right eye
H25.22	Age-related cataract, morgagnian type, left eye
H25.23	Age-related cataract, morgagnian type, bilateral
H25.811	Combined forms of age-related cataract, right eye
H25.812	Combined forms of age-related cataract, left eye
H25.813	Combined forms of age-related cataract, bilateral
H25.89	Other age-related cataract
H25.9	Unspecified age-related cataract
H26.001	Unspecified infantile and juvenile cataract, right eye
H26.002	Unspecified infantile and juvenile cataract, left eye
H26.003	Unspecified infantile and juvenile cataract, bilateral
H26.031	Infantile and juvenile nuclear cataract, right eye
H26.032	Infantile and juvenile nuclear cataract, left eye
H26.033	Infantile and juvenile nuclear cataract, bilateral
H26.061	Combined forms of infantile and juvenile cataract, right eye
H26.062	Combined forms of infantile and juvenile cataract, left eye
H26.063	Combined forms of infantile and juvenile cataract, bilateral
H26.09	Other infantile and juvenile cataract
H26.101	Unspecified traumatic cataract, right eye
H26.102	Unspecified traumatic cataract, left eye
H26.103	Unspecified traumatic cataract, bilateral
H26.111	Localized traumatic opacities, right eye
H26.112	Localized traumatic opacities, left eye
H26.113	Localized traumatic opacities, bilateral
H26.121	Partially resolved traumatic cataract, right eye
H26.122	Partially resolved traumatic cataract, left eye
H26.123	Partially resolved traumatic cataract, bilateral
H26.131	Total traumatic cataract, right eye
H26.132	Total traumatic cataract, left eye
H26.133	Total traumatic cataract, bilateral
H26.221	Cataract secondary to ocular disorders (degenerative) (inflammatory), right eye
H26.222	Cataract secondary to ocular disorders (degenerative) (inflammatory), left eye
H26.223	Cataract secondary to ocular disorders (degenerative) (inflammatory), bilateral
H26.31	Drug-induced cataract, right eye
H26.32	Drug-induced cataract, left eye
H26.33	Drug-induced cataract, bilateral

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
H26.40	Unspecified secondary cataract
H26.411	Soemmering's ring, right eye
H26.412	Soemmering's ring, left eye
H26.413	Soemmering's ring, bilateral
H26.491	Other secondary cataract, right eye
H26.492	Other secondary cataract, left eye
H26.493	Other secondary cataract, bilateral
H26.8	Other specified cataract
H26.9	Unspecified cataract
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
H2.710	Unspecified dislocation of lens
H27.111	Subluxation of lens, right eye
H27.112	Subluxation of lens, left eye
H27.113	Subluxation of lens, bilateral
H27.131	Posterior dislocation of lens, right eye
H27.132	Posterior dislocation of lens, left eye
H27.133	Posterior dislocation of lens, bilateral
H28	Cataract in diseases classified elsewhere
H30.101	Unspecified disseminated chorioretinal inflammation, right eye
H30.102	Unspecified disseminated chorioretinal inflammation, left eye
H30.103	Unspecified disseminated chorioretinal inflammation, bilateral
H30.131	Disseminated chorioretinal inflammation, generalized, right eye
H30.132	Disseminated chorioretinal inflammation, generalized, left eye
H30.133	Disseminated chorioretinal inflammation, generalized, bilateral
H30.891	Other chorioretinal inflammations, right eye
H30.892	Other chorioretinal inflammations, left eye
H30.893	Other chorioretinal inflammations, bilateral
H30.811	Harada's disease, right eye
H30.812	Harada's disease, left eye
H30.813	Harada's disease, bilateral
H30.91	Unspecified chorioretinal inflammation, right eye
H30.92	Unspecified chorioretinal inflammation, left eye
H30.93	Unspecified chorioretinal inflammation, bilateral
H31.301	Unspecified choroidal hemorrhage, right eye
H31.302	Unspecified choroidal hemorrhage, left eye
H31.303	Unspecified choroidal hemorrhage, bilateral
H31.401	Unspecified choroidal detachment, right eye
H31.402	Unspecified choroidal detachment, left eye
H31.403	Unspecified choroidal detachment, bilateral
H31.411	Hemorrhagic choroidal detachment, right eye
H31.412	Hemorrhagic choroidal detachment, left eye
H31.413	Hemorrhagic choroidal detachment, bilateral
H33.001	Unspecified retinal detachment with retinal break, right eye

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
H33.002	Unspecified retinal detachment with retinal break, left eye
H33.003	Unspecified retinal detachment with retinal break, bilateral
H33.011	Retinal detachment with single break, right eye
H33.012	Retinal detachment with single break, left eye
H33.013	Retinal detachment with single break, bilateral
H33.021	Retinal detachment with multiple breaks, right eye
H33.022	Retinal detachment with multiple breaks, left eye
H33.023	Retinal detachment with multiple breaks, bilateral
H33.031	Retinal detachment with giant retinal tear, right eye
H33.032	Retinal detachment with giant retinal tear, left eye
H33.033	Retinal detachment with giant retinal tear, bilateral
H33.041	Retinal detachment with retinal dialysis, right eye
H33.042	Retinal detachment with retinal dialysis, left eye
H33.043	Retinal detachment with retinal dialysis, bilateral
H33.051	Total retinal detachment, right eye
H33.052	Total retinal detachment, left eye
H33.053	Total retinal detachment, bilateral
H33.101	Unspecified retinoschisis, right eye
H33.102	Unspecified retinoschisis, left eye
H33.103	Unspecified retinoschisis, bilateral
H33.191	Other retinoschisis and retinal cysts, right eye
H33.192	Other retinoschisis and retinal cysts, left eye
H33.193	Other retinoschisis and retinal cysts, bilateral
H33.21	Serous retinal detachment, right eye
H33.22	Serous retinal detachment, left eye
H33.23	Serous retinal detachment, bilateral
H33.41	Traction detachment of retina, right eye
H33.42	Traction detachment of retina, left eye
H33.43	Traction detachment of retina, bilateral
H33.301	Unspecified retinal break, right eye
H33.302	Unspecified retinal break, left eye
H33.303	Unspecified retinal break, bilateral
H33.311	Horseshoe tear of retina without detachment, right eye
H33.312	Horseshoe tear of retina without detachment, left eye
H33.313	Horseshoe tear of retina without detachment, bilateral
H33.331	Multiple defects of retina without detachment, right eye
H33.332	Multiple defects of retina without detachment, left eye
H33.333	Multiple defects of retina without detachment, bilateral
H33.8	Other retinal detachments
H34.8110	Central retinal vein occlusion, right eye, with macular edema
H34.8111	Central retinal vein occlusion, right eye, with retinal neovascularization
H34.8120	Central retinal vein occlusion, left eye, with macular edema
H34.8121	Central retinal vein occlusion, left eye, with retinal neovascularization
H34.8130	Central retinal vein occlusion, bilateral, with macular edema
H34.8131	Central retinal vein occlusion, bilateral, with retinal neovascularization

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
H35.341	Macular cyst, hole, or pseudohole, right eye
H35.342	Macular cyst, hole, or pseudohole, left eye
H35.343	Macular cyst, hole, or pseudohole, bilateral
H35.371	Puckering of macula, right eye
H35.372	Puckering of macula, left eye
H35.373	Puckering of macula, bilateral
H35.021	Exudative retinopathy, right eye
H35.022	Exudative retinopathy, left eye
H35.023	Exudative retinopathy, bilateral
H35.051	Retinal neovascularization, unspecified, right eye
H35.052	Retinal neovascularization, unspecified, left eye
H35.053	Retinal neovascularization, unspecified, bilateral
H35.061	Retinal vasculitis, right eye
H35.062	Retinal vasculitis, left eye
H35.063	Retinal vasculitis, bilateral
H35.071	Retinal telangiectasis, right eye
H35.072	Retinal telangiectasis, left eye
H35.073	Retinal telangiectasis, bilateral
H35.101	Retinopathy of prematurity, unspecified, right eye
H35.102	Retinopathy of prematurity, unspecified, left eye
H35.103	Retinopathy of prematurity, unspecified, bilateral
H35.161	Retinopathy of prematurity, stage 5, right eye
H35.162	Retinopathy of prematurity, stage 5, left eye
H35.163	Retinopathy of prematurity, stage 5, bilateral
H35.50	Unspecified hereditary retinal dystrophy
H35.51	Vitreoretinal dystrophy
H35.52	Pigmentary retinal dystrophy
H35.81	Retinal edema
H35.21	Other non-diabetic proliferative retinopathy, right eye
H35.22	Other non-diabetic proliferative retinopathy, left eye
H35.23	Other non-diabetic proliferative retinopathy, bilateral
H35.61	Retinal hemorrhage, right eye
H35.62	Retinal hemorrhage, left eye
H35.63	Retinal hemorrhage, bilateral
H40.89	Other specified glaucoma
H40.831	Aqueous misdirection, right eye
H40.832	Aqueous misdirection, left eye
H40.833	Aqueous misdirection, bilateral
H43.01	Vitreous prolapse, right eye
H43.02	Vitreous prolapse, left eye
H43.03	Vitreous prolapse, bilateral
H43.311	Vitreous membranes and strands, right eye
H43.312	Vitreous membranes and strands, left eye
H43.313	Vitreous membranes and strands, bilateral
H43.821	Vitreomacular adhesion, right eye

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

ICD-10 CM	ICD-10 DX Description
H43.822	Vitreomacular adhesion, left eye
H43.823	Vitreomacular adhesion, bilateral
H43.811	Vitreous degeneration, right eye
H43.812	Vitreous degeneration, left eye
H43.813	Vitreous degeneration, bilateral
H43.89	Other disorders of vitreous body
H43.9	Unspecified disorder of vitreous body
H4311	Vitreous hemorrhage, right eye
H4312	Vitreous hemorrhage, left eye
H4313	Vitreous hemorrhage, bilateral
H4321	Crystalline deposits in vitreous body, right eye
H4322	Crystalline deposits in vitreous body, left eye
H4323	Crystalline deposits in vitreous body, bilateral
H43391	Other vitreous opacities, right eye
H43392	Other vitreous opacities, left eye
H43393	Other vitreous opacities, bilateral
H44.001	Unspecified purulent endophthalmitis, right eye
H44.002	Unspecified purulent endophthalmitis, left eye
H44.003	Unspecified purulent endophthalmitis, bilateral
H44.021	Vitreous abscess (chronic), right eye
H44.022	Vitreous abscess (chronic), left eye
H44.023	Vitreous abscess (chronic), bilateral
H44.19	Other endophthalmitis
H44.601	Unspecified retained (old) intraocular foreign body, magnetic, right eye
H44.602	Unspecified retained (old) intraocular foreign body, magnetic, left eye
H44.603	Unspecified retained (old) intraocular foreign body, magnetic, bilateral
H44.641	Retained (old) magnetic foreign body in posterior wall of globe, right eye
H44.642	Retained (old) magnetic foreign body in posterior wall of globe, left eye
H44.643	Retained (old) magnetic foreign body in posterior wall of globe, bilateral
H44.651	Retained (old) magnetic foreign body in vitreous body, right eye
H44.652	Retained (old) magnetic foreign body in vitreous body, left eye
H44.653	Retained (old) magnetic foreign body in vitreous body, bilateral
H44.691	Retained (old) intraocular foreign body, magnetic, in other or multiple sites, right eye
H44.692	Retained (old) intraocular foreign body, magnetic, in other or multiple sites, left eye
H44.693	Retained (old) intraocular foreign body, magnetic, in other or multiple sites, bilateral
H44.701	Unspecified retained (old) intraocular foreign body, nonmagnetic, right eye
H44.702	Unspecified retained (old) intraocular foreign body, nonmagnetic, left eye
H44.703	Unspecified retained (old) intraocular foreign body, nonmagnetic, bilateral
H44.741	Retained (nonmagnetic) (old) foreign body in posterior wall of globe, right eye
H44.742	Retained (nonmagnetic) (old) foreign body in posterior wall of globe, left eye
H44.743	Retained (nonmagnetic) (old) foreign body in posterior wall of globe, bilateral
H44.751	Retained (nonmagnetic) (old) foreign body in vitreous body, right eye
H44.752	Retained (nonmagnetic) (old) foreign body in vitreous body, left eye
H44.753	Retained (nonmagnetic) (old) foreign body in vitreous body, bilateral
H44.791	Retained (old) intraocular foreign body, nonmagnetic, in other or multiple sites, right eye

NCD:	80.11
NCD Title:	Vitrectomy
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

		ICD-10 CM	ICD-10 DX Description
		H44.792	Retained (old) intraocular foreign body, nonmagnetic, in other or multiple sites, left eye

NCD:	80.11		
NCD Title:	Vitrectomy		
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10 PCS	**ICD-10 PCS Description**
		N/A	N/A

NCD:	80.11
NCD Title:	Vitrectomy (CR4278, CR7818, CR9252, CR9861, CR10086, CR10318, CR10859, CR11005)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
		67036								
		67039								
	FISS (59015/59016) & A/MACs: Shall allow HCPCS/CPT codes	67040		13X						
	when billed with payable diagnoses with approved HCPCs/CPT	67041		18X						
	codes. Vitrectomy may be considered reasonable and necessary	67042		21X	036X			Dx=36.1	50	
Part A	for this condition	67043	N/A	85X	049X	N/A	N/A	36.2	58	NA

NCD:	80.11
NCD Title:	Vitrectomy (CR4278, CR7818, CR9252, CR9861, CR10086, CR10318, CR10859, CR11005)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**MCS (007L) & B/MACs:** Shall allow HCPCS/CPT codes when billed with payable diagnoses with approved HCPCs/CPT codes. Vitrectomy may be considered reasonable and necessary for this condition	67036 67039 67040 67041 67042 67043	N/A	N/A	N/A	N/A	N/A	15.20 14.9 15.4	11 50	N386

REVISION HISTORY	
	CR9252: Per Palmetto remove NOC codes. FISS will do so 4/4/16.
	Per CMS do not include suffixes for subsequent & sequela. Inclusion of these codes does not follow from GEMs. Adding them is expanding coverage and is not supported clinically. CPTs addressed by 80.11 are various vitrectomies (corrective surgical treatments to eye). These procedures represent active tx of patient. By definition, S0521XD represents patient who finished active tx and receiving routine care during healing/recovery. S0521XS represents sequela, complications/conditions that arise from injury/tx, no reason to believe vitrectomy is suitable tx for sequela of injury/tx. Vitrectomy is to treat active condition itself (represented by S0521XA). Review pages 14 & 66 of "ICD-10-CM Official Guidelines for Coding and Reporting FY 2015" available at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/icd10cm-guidelines-2015.pdf.
	Correction: Line 7 - Change TOB 25X to 85X due to typo.
	Remove RARC M76 per CMS Remittance Advice Team
	CR9861: Add 2017 ICD-10 dx effective 10/1/16: E08.3511,E08.3512,E08.3513,E08.3521,E08.3522,E08.3523,E08.3531,E08.3532,E08.3533,E08.3541,E08.3542,E08.3543,E08.3551,E08.3552,E08.3553,E08.3591,E08.3592,E08.3593, E09.3511,E09.3512,E09.3513,E09.3521,E09.3522,E09.3523,E09.3531,E09.3532,E09.3533,E09.3541,E09.3542,E09.3543,E09.3551,E09.3552,E09.3553,E09.3591,E09.3592,E09.3593, E10.3511,E10.3512,E10.3513,E10.3521,E10.3522,E10.3523,E10.3531,E10.3532,E10.3533,E10.3541,E10.3542,E10.3543,E10.3551,E10.3552,E10.3553,E10.3591,E10.3592,E10.3593, E11.3511,E11.3512,E11.3513,E11.3521,E11.3522,E11.3523,E11.3531,E11.3532,E11.3533,E11.3541,E11.3542,E11.3543,E11.3551,E11.3552,E11.3553,E11.3591,E11.3592,E11.3593, E13.3511,E13.3512,E13.3513,E13.3521,E13.3522,E13.3523,E13.3531,E13.3532,E13.3533,E13.3541,E13.3542,E13.3543,E13.3551,E13.3552,E13.3553,E13.3591,E13.3592,E13.3593 Remove ICD-10 dx: E08.37X1,E08.37X2,E08.37X3,E09.3211,E09.3212,E09.3213,E09.37X1,E09.37X2,E09.37X3,E11.37X1,E11.37X2,E11.37X3,E13.37X1,E13.37X2,E13.37X3.
	End-date expired ICD-10 dx codes effective 9/30/16: E08.351, E08.359, E09.321, E09.351, E09.359, E10.351, E10.359, E11.351, E11.359, E13.351, E13.359. Remove unspecified ICD-10 dx codes because laterality codes are available effective 1/1/17: H30.90, H33.20.
	CR10086: End-date ICD-10 dx H34.811, H34.812, H34.813 effective 9/30/16. Delete ICD-10 dx H40.20 effective 10/1/15. Remove ICD-9 dx codes. Add ICD-10 dx H34.8110-H34.8112, H34.8120-H34.8122, H34.8130-H34.8132 effective 10/1/16. (MCS 007L, FISS 59015, 59016)

NCD:	80.11
NCD Title:	Vitrectomy (CR4278, CR7818, CR9252, CR9861, CR10086, CR10318, CR10859, CR11005)
IOM:	http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=18&ncdver=2&DocID=80.11&SearchType=Advanced&bc=IAAAAAgAAAAA&
	CR10318: Effective 9/30/17, delete the following ICD-10 codes: E08.3511, E08.3512, E08.3513, E08.3551, E08.3552, E08.3553, E08.3591, E08.3593, E08.3592, E09.3511, E09.3512, E09.3513, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.3511, E10.3512, E10.3513, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E11.3511, E11.3512, E11.3513, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E13.3511, E13.3512, E13.3513, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593, H35.92, H35.93, A18.53, H30.91, H30.92, H30.93, H30.101, H30.102, H30.103, H30.131, H30.132, H30.133, H30.891, H30.892, H30.893, H16.241, H16.242, H16.243, H40.89, H40.831, H40.832, H40.833, H44.131, H44.132, H44.133, Z98.83, A18.54, H20.11, H20.12, H20.13, H20.21, H20.22, H20.23, E08.36, E09.36, E10.36, E11.36, E13.36, H25.011, H25.012, H25.013, H25.031, H25.032, H25.033, H25.041, H25.042, H25.043, H25.091, H25.092, H25.093, H25.11, H25.12, H25.13, H25.21, H25.22, H25.23, H25.811, H25.812, H25.813, H25.89, H25.9, H26.001, H26.002, H26.003, H26.031, H26.032, H26.033, H26.061, H26.062, H26.063, H26.09, H26.101, H26.102, H26.103, H26.111, H26.112, H26.113, H26.121, H26.122, H26.123, H26.131, H26.132, H26.133, H26.221, H26.222, H26.223, H26.31, H26.32, H26.33, H26.40, H26.411, H26.412, H26.413, H26.491, H26.492, H26.493, H26.8, H26.9, H28, H27.01, H27.02, H27.03, H27.10, H27.111, H27.112, H27.113, H27.131, H27.132, H27.133, H59.011, H59.012, H59.013, H59.021, H59.022, H59.023, H59.091, H59.092, H59.093 H51.093, T85.21xA, T85.22xA, T85.29xA, Z98.41, Z98.42, H20.821, H20.822, H20.823, H30.811, H30.812, H30.813, H31.301, H31.302, H31.303, H31.321, H31.322, H31.323, H31.401, H31.402, H31.403, H31.411, H31.412, H31.413, H59.811, H59.812, H59.813, S05.21xA, S05.22xA, S05.31xA, S05.32xA, S05.51xA, S05.52xA, S05.61xA, S05.62xA, S05.71xA, S05.72xA, S05.8x1A, S05.8x2A, S05.91xA, S05.92xA, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.101, H33.102, H33.103, H33.111, H33.112, H33.113, H33.191, H33.192, H33.193, H33.21, H33.22, H33.23, H33.301, H33.302, H33.303, H33.311, H33.312, H33.313, H33.331, H33.332, H33.333, H33.8, H43.311, H43.312, H43.313, H43.821, H43.822, H43.823, H33.321, H33.322, H33.323, H35.341, H35.342, H35.343, H35.361, H35.362, H35.363, H35.371, H35.372, H35.373, H35.021, H35.022, H35.023, H35.061, H35.051, H35.052, H35.053, H35.062, H35.063, H35.071, H35.072, H35.073, H35.101, H35.102, H35.103, H35.51, H43.811, H43.812, H43.813, H43.89, H43.9, H44.311, H44.312, H44.313, H44.321, H44.322, H44.323, H44.601, H44.602, H44.603, H44.641, H44.642, H44.643, H44.651, H44.652, H44.653, H44.691, H44.692, H44.693, H44.701, H44.702, H44.703, H44.741, H44.742, H44.743, H44.751, H44.752, H44.753, H44.791, H44.792, H44.793, H35.30, H35.81, H59.031, H59.032, H59.033, E11.39, H59.88, H59.89, Q12.0, Q12.1, Q12.2, Q12.3, Q12.4, Q12.8, Q12.9, Q14.0, Q14.1, H35.21, H35.22, H35.23, H35.61, H35.62, H35.63, H43.11, H43.12, H43.13, H43.21, H43.22, H43.23, H43.391, H43.392, H43.393.

NCD:	220.4		
NCD Title:	Mammogrmas		
IOM:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&		
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf		
		ICD-10 CM	**ICD-10 DX Description**
			CMS reserves the right to add or remove codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy
			Part I Screening Mammograms
		Z12.31	Encounter for screening mammogram for malignant neoplasm of breast
			Part II Diagnostic Mammograms
		C43.52	Malignant melanoma of skin of breast
		C43.59	Malignant melanoma of other part of trunk
		D03.52	Melanoma in situ of breast (skin) (soft tissue)
		D03.59	Melanoma in situ of other part of trunk
		C44.501	Unspecified malignant neoplasm of skin of breast
		C44.509	Unspecified malignant neoplasm of skin of other part of trunk
		C44.511	Basal cell carcinoma of skin of breast
		C44.519	Basal cell carcinoma of skin of other part of trunk
		C44.521	Squamous cell carcinoma of skin of breast
		C44.529	Squamous cell carcinoma of skin of other part of trunk
		C44.591	Other specified malignant neoplasm of skin of breast
		C44.599	Other specified malignant neoplasm of skin of other part of trunk
		C50.011	Malignant neoplasm of nipple and areola, right female breast
		C50.012	Malignant neoplasm of nipple and areola, left female breast
		C50.111	Malignant neoplasm of central portion of right female breast
		C50.112	Malignant neoplasm of central portion of left female breast
		C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
		C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
		C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
		C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
		C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
		C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
		C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
		C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
		C50.611	Malignant neoplasm of axillary tail of right female breast
		C50.612	Malignant neoplasm of axillary tail of left female breast
		C50.811	Malignant neoplasm of overlapping sites of right female breast
		C50.812	Malignant neoplasm of overlapping sites of left female breast
		C50.911	Malignant neoplasm of unspecified site of right female breast
		C50.912	Malignant neoplasm of unspecified site of left female breast
		C50.021	Malignant neoplasm of nipple and areola, right male breast
		C50.022	Malignant neoplasm of nipple and areola, left male breast
		C50.121	Malignant neoplasm of central portion of right male breast
		C50.122	Malignant neoplasm of central portion of left male breast
		C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
		C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
		C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
		C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
		C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
		C50.422	Malignant neoplasm of upper-outer quadrant of left male breast

		ICD-10 CM	ICD-10 DX Description
		C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
		C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
		C50.621	Malignant neoplasm of axillary tail of right male breast
		C50.622	Malignant neoplasm of axillary tail of left male breast
		C50.821	Malignant neoplasm of overlapping sites of right male breast
		C50.822	Malignant neoplasm of overlapping sites of left male breast
		C50.921	Malignant neoplasm of unspecified site of right male breast
		C50.922	Malignant neoplasm of unspecified site of left male breast
		C56.1	Malignant neoplasm of right ovary
		C56.2	Malignant neoplasm of left ovary
		C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
		C78.01	Secondary malignant neoplasm of right lung
		C78.02	Secondary malignant neoplasm of left lung
		C78.1	Secondary malignant neoplasm of mediastinum
		C78.2	Secondary malignant neoplasm of pleura
		C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
		C79.2	Secondary malignant neoplasm of skin
		C79.31	Secondary malignant neoplasm of brain
		C79.32	Secondary malignant neoplasm of cerebral meninges
		C79.40	Secondary malignant neoplasm of unspecified part of nervous system
		C79.49	Secondary malignant neoplasm of other parts of nervous system
		C79.51	Secondary malignant neoplasm of bone
		C79.52	Secondary malignant neoplasm of bone marrow
		C79.61	Secondary malignant neoplasm of right ovary
		C79.62	Secondary malignant neoplasm of left ovary
		C79.81	Secondary malignant neoplasm of breast
		C80.0	Disseminated malignant neoplasm, unspecified
		C45.9	Mesothelioma, unspecified
		C80.1	Malignant (primary) neoplasm, unspecified
		D22.5	Melanocytic nevi of trunk
		D23.5	Other benign neoplasm of skin of trunk
		D24.1	Benign neoplasm of right breast
		D24.2	Benign neoplasm of left breast
		D04.5	Carcinoma in situ of skin of trunk
		D05.01	Lobular carcinoma in situ of right breast
		D05.02	Lobular carcinoma in situ of left breast
		D05.11	Intraductal carcinoma in situ of right breast
		D05.12	Intraductal carcinoma in situ of left breast
		D05.81	Other specified type of carcinoma in situ of right breast
		D05.82	Other specified type of carcinoma in situ of left breast
		D05.91	Unspecified type of carcinoma in situ of right breast
		D05.92	Unspecified type of carcinoma in situ of left breast
		D48.5	Neoplasm of uncertain behavior of skin
		D48.61	Neoplasm of uncertain behavior of right breast
		D48.62	Neoplasm of uncertain behavior of left breast
		D49.1	Neoplasm of unspecified behavior of respiratory system
		D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
		D49.3	Neoplasm of unspecified behavior of breast
		D49.6	Neoplasm of unspecified behavior of brain

		ICD-10 CM	ICD-10 DX Description
		D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
		I80.8	Phlebitis and thrombophlebitis of other sites
		N60.01	Solitary cyst of right breast
		N60.02	Solitary cyst of left breast
		N60.11	Diffuse cystic mastopathy of right breast
		N60.12	Diffuse cystic mastopathy of left breast
		N60.21	Fibroadenosis of right breast
		N60.22	Fibroadenosis of left breast
		N60.31	Fibrosclerosis of right breast
		N60.32	Fibrosclerosis of left breast
		N60.41	Mammary duct ectasia of right breast
		N60.42	Mammary duct ectasia of left breast
		N60.81	Other benign mammary dysplasias of right breast
		N60.82	Other benign mammary dysplasias of left breast
		N60.91	Unspecified benign mammary dysplasia of right breast
		N60.92	Unspecified benign mammary dysplasia of left breast
		N62	Hypertrophy of breast
		N61.0	Mastitis without abscess
		N61.1	Abscess of the breast and nipple
		N64.0	Fissure and fistula of nipple
		N64.1	Fat necrosis of breast
		N64.2	Atrophy of breast
		N64.89	Other specified disorders of breast
		N64.3	Galactorrhea not associated with childbirth
		N64.4	Mastodynia
	NOTE: Dual dx codes depicting specific quadrants can be reported instead of unspecified quadrants if found more appropriate by provider.	N63.10	Unspecified lump, unspecified quadrant, right breast
		N63.11	Unspecified lump in right breast, upper outer quadrant
		N63.12	Unspecified lump in right breast, upper inner quadrant
		N63.13	Unspecified lump in right breast, lower outer quadrant
		N63.14	Unspecified lump in right breast, lower inner quadrant
	NOTE: Dual dx codes depicting specific quadrants can be reported instead of unspecified quadrants if found more appropriate by provider.	N63.20	Unspecified lump, unspecified quadrant, left breast
		N63.21	Unspecified lump in the left breast, upper outer quadrant
		N63.22	Unspecified lump in left breast, upper inner quadrant
		N63.23	Unspecified lump in the left breast, lower outer quadrant
		N63.24	Unspecified lump in the left breast, lower inner quadrant
		N63.31	Unspecified lump in axillary tail of the right breast
		N63.32	Unspecified lump in axillary tail of the left breast
		N63.41	Unspecified lump in right breast, subareolar
		N63.42	Unspecified lump in left breast, subareolar
		N64.51	Induration of breast
		N64.52	Nipple discharge
		N64.53	Retraction of nipple
		N64.59	Other signs and symptoms in breast
		N64.81	Ptosis of breast
		N64.82	Hypoplasia of breast
		N64.89	Other specified disorders of breast
		N64.9	Disorder of breast, unspecified
		N65.0	Deformity of reconstructed breast

		ICD-10 CM	ICD-10 DX Description
		N65.1	Disproportion of reconstructed breast
		M79.5	Residual foreign body in soft tissue
		M70.90	Unspecified soft tissue disorder related to use, overuse and pressure of unspecified site
		M70.98	Unspecified soft tissue disorder related to use, overuse and pressure other
		M70.99	Unspecified soft tissue disorder related to use, overuse and pressure multiple sites
		M79.9	Soft tissue disorder, unspecified
		M79.81	Nontraumatic hematoma of soft tissue
		M70.80	Other soft tissue disorders related to use, overuse and pressure of unspecified site
		M70.88	Other soft tissue disorders related to use, overuse and pressure other site
		M70.89	Other soft tissue disorders related to use, overuse and pressure multiple sites
		M79.89	Other specified soft tissue disorders
		R59.0	Localized enlarged lymph nodes
		R59.1	Generalized enlarged lymph nodes
		R59.9	Enlarged lymph nodes, unspecified
		R92.8	Other abnormal and inconclusive findings on diagnostic imaging of breast
		R92.0	Mammographic microcalcification found on diagnostic imaging of breast
		R92.2	Inconclusive mammogram
		R92.1	Mammographic calcification found on diagnostic imaging of breast
		R93.9	Diagnostic imaging inconclusive due to excess body fat of patient
		S21.001A	Unspecified open wound of right breast, initial encounter
		S21.002A	Unspecified open wound of left breast, initial encounter
		S21.011A	Laceration without foreign body of right breast, initial encounter
		S21.012A	Laceration without foreign body of left breast, initial encounter
		S21.031A	Puncture wound without foreign body of right breast, initial encounter
		S21.032A	Puncture wound without foreign body of left breast, initial encounter
		S21.051A	Open bite of right breast, initial encounter
		S21.052A	Open bite of left breast, initial encounter
		S28.211A	Complete traumatic amputation of right breast, initial encounter
		S28.212A	Complete traumatic amputation of left breast, initial encounter
		S28.221A	Partial traumatic amputation of right breast, initial encounter
		S28.222A	Partial traumatic amputation of left breast, initial encounter
		S21.021A	Laceration with foreign body of right breast, initial encounter
		S21.022A	Laceration with foreign body of left breast, initial encounter
		S21.041A	Puncture wound with foreign body of right breast, initial encounter
		S21.042A	Puncture wound with foreign body of left breast, initial encounter
		S20.01xA	Contusion of right breast, initial encounter
		S20.02xA	Contusion of left breast, initial encounter
		S29.001A	Unspecified injury of muscle and tendon of front wall of thorax, initial encounter
		S29.009A	Unspecified injury of muscle and tendon of unspecified wall of thorax, initial encounter
		S29.091A	Other injury of muscle and tendon of front wall of thorax, initial encounter
		S29.099A	Other injury of muscle and tendon of unspecified wall of thorax, initial encounter
		S29.8xxA	Other specified injuries of thorax, initial encounter
		S29.9xxA	Unspecified injury of thorax, initial encounter
		S39.001A	Unspecified injury of muscle, fascia and tendon of abdomen, initial encounter
		S39.091A	Other injury of muscle, fascia and tendon of abdomen, initial encounter
		S39.81xA	Other specified injuries of abdomen, initial encounter
		S39.91xA	Unspecified injury of abdomen, initial encounter
		T85.41xA	Breakdown (mechanical) of breast prosthesis and implant, initial encounter
		T85.42xA	Displacement of breast prosthesis and implant, initial encounter

		ICD-10 CM	ICD-10 DX Description
		T85.43xA	Leakage of breast prosthesis and implant, initial encounter
		T85.44xA	Capsular contracture of breast implant, initial encounter
		T85.49xA	Other mechanical complication of breast prosthesis and implant, initial encounter
		T85.79xA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
		Z85.3	Personal history of malignant neoplasm of breast
		Z85.831	Personal history of malignant neoplasm of soft tissue
		Z85.89	Personal history of malignant neoplasm of other organs and systems
		Z77.123	Contact with and (suspected) exposure to radon and other naturally occuring radiation
		Z77.128	Contact with and (suspected) exposure to other hazards in the physical environment
		Z77.9	Other contact with and (suspected) exposures hazardous to health
		Z86.000	Personal history of in-situ neoplasm of breast
		Z91.89	Other specified personal risk factors, not elsewhere classified
		Z92.89	Personal history of other medical treatment
		Z98.82	Breast implant status
		Z98.86	Personal history of breast implant removal
		Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
		Z03.89	Encounter for observation for other suspected diseases and conditions ruled out

NCD:	220.4		
NCD Title:	Mammograms		
IOM:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&		
MCD:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf		
		ICD-10	**ICD-10 PCS Description**
		N/A	N/A

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
5											
6	**Part A**	**Rule Description Part A**	**Proposed HCPCS/CPT Part A**	**Frequency Limitations**	**TOB (Part A)**	**Revenue Code Part A**	**Modifier Part A**	**Provider Specialty**	**Proposed MSN Message Part A**	**Proposed CARC Message Part A**	**Proposed RARC Message Part A**
7	**Part A**	**A/MACs & FISS (RC 59172/59173)** shall reprogram any applicable edits currently in place that require the reporting of dx Z12.31 as primary on claims containing **screening** mammography services. **A/MACs & FISS** shall reprogram such edits so that dx Z12.31 need not be reported as primary if the claim contains services other than screening mammography services In reprogramming such edits, **A/MACs & FISS** shall ensure that edits require dx Z12.31 reported as primary on claims containing only screening mammography.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403	n/a	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
8	**Part A**	**A/MAC**: Effective for claims with DOS on and after 1/1/18 pay for CPT 77063, screening digital breast tomosynthesis, bilateral, when submitted as add-on code with CPT 77067, screening mammography producing direct digital image, bilateral, all views, and dx Z12.31. The same frequency rules apply.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403 097X 098X	Group Code CO (if GZ present), or PR (if GA present)	N/A	N/A	167	N386
9	**Part A**	**A/MACs** shall instruct providers to continue reporting dx Z12.31 as primary on claims that contain only **screening** mammography services. **A/MACs** shall instruct providers to report dx Z12.31 as secondary on claims that contain other services in addition to screening mammography.	1/1/18 Screening: 77063 77067	1 **screening** mammogram per asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403	n/a	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
10	**Part A**	The technical component (TC) portion of the **screening** mammography is billed on Form CMS-1450 under TOB 13X, 22X, 23X, or 85X using revenue codes 0403	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403	TC	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
11	**Part A**	**CWF: Only 1 screening (baseline)** mammogram per asymptomatic female over 34 but under 40.	1/1/18 Screening: 77063 77067	1 **screening** (baseline) mammogram asymptomatic female >34 <40.	13X 22X 23X 71X 77X 85X	0403	n/a	n/a	18.6	119	M89
12	**Part A**	**CWF:** Over 39, 1 **screening** mammogram after at least 11 months following month in which last screening was performed.	1/1/18 Screening: 77063 77067	>39=1 **screening** mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403	n/a	n/a	Option 18.12 18.4	119	M90
13		**A/MACs:** effective for claims with DOS on and after 1/1/18, recognize CPT 77063 only when billed in conjunction with HCPCS 77067. Beneficiary coinsurance and deductible does not apply to claim line with HCPCS 77063. Only allow payment for CPT 77063 when dx Z12.31 or RTP. For claims submitted without dx Z12.31, deny claim line for HCPCS 77063.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403 096X 097X 098X	n/a	n/a	14.9	167	N386

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
14	**Part A**	**A/MACs:** Effective for claims with DOS on and after 1/1/15, shall RTP any claim submitted with tomosynthesis CPT 77063 when TOB is not 13X, 22X, 23X, or 85X, and revenue code is not 0403, 096X, 097X, 098X.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	13X 22X 23X 71X 77X 85X	0403 096X 097X 098X	n/a	n/a	14.9	167	N386
15	**Part A**	If **screening** and **dx** mamogram are performed on same DOS modifier -GG is required.	1/1/18 Screening: 77063 77067 1/1/18 Diagnostic: 77065 77066 G0279	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	12X 13X 22X 23X 71X 77X 85X	0401	GG: this modifier applies to dx codes only	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
16	**Part A**	The -TC portion of the **diagnostic** mammography is billed on Form CMS-1450 under bill type 12X, 13X, 22X, 23X or 85X using revenue codes 0401.	1/1/18 Diagnostic: 77065 77066 G0279	n/a	12X 13X 22X 23X 71X 77X 85X	0401	TC	n/a	15.20 15.4	11 50 107 167 B15	N386
17	**Part A**	**A/MACs** effective DOS 1/1/18, shall add HCPCS G0279, **diagnostic** digital breast tomosynthesis, unilateral or bilateral, to claims containing CPT 77066, diagnostic mammography, producing direct 2-D digital image, bilateral, all views, and 77065, diagnostic mammography, producing direct 2-D digtal image, unilateral, all views.	1/1/18 Diagnostic: 77065 77066 G0279	n/a	12X 13X 22X 23X 71X 77X 85X	0401	n/a	n/a	9.2	107	MA66

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
18											
19											
20	**Part B**	**Rule Description Part B**	**Proposed HCPCS/CPT Part B**	**Frequency Limitations**	**POS (Part B)**	**n/a**	**Modifier Part B**	**Provider Specialty**	**Proposed MSN Message Part B**	**Proposed CARC Message Part B**	**Proposed RARC Message Part B**
21	**Part B**	**B/MACs & MCS (051L)** shall reprogram any applicable current edits that require reporting of dx Z12.31 as primary on claims containing screening mammography services. **B/MACs & MCS** shall reprogram such edits so that dx Z12.31 need not be reported as primary if claim contains services other than screening mammography services. **B/MACs** shall instruct providers to continue reporting dx Z12.31 as primary on claims that contain **only screening** mammography services. **B/MACs** shall instruct providers to report dx Z12.31 as secondary on claims that contain other services in addition to screening mammography.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
22	**Part B**	**B/MACs:** Effective for claims with DOS on and after 10/1/03, are no longer permitted to add dx codes for screening mammography when screening mammography claim has no dx code. Screening mammography claims with no dx code must be returned as unprocessable for assigned claims. For unassigned claims, deny.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	15.20 18.12 18.6	107 B15	N386
23		**B/MACs:** Effective for claims with DOS on and after 1/1/18, recognize CPT 77063 only when billed in conjunction with CPT 77067. Beneficiary coinsurance and deductible does not apply to claim line with CPT 77063. Only allow payment for CPT 77063 when dx Z12.31 or RTP. For claims submitted without Z12.31 deny claim line for CPT 77063.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	14.9	167	N386

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
24	**Part B**	**B/MACs**: if claim does not contain facility's 6-digit certification number, or if 6-digit certification number is not reported in item 32 of CMS-1500 paper claim, or in the 2400 loop (REF 02 segment, where 01=EW segment) of the ASC X12N 837 professional version 4010A1, electronic claim, return claim as unprocessable.	1/1/18 Screening: 77063 77067 1/1/18 Diagnostic: 77065 77066 G0279	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	15.20 15.20	171 film/dig 171 film/dig	N92 dig N110 film
25	**Part B**	**B/MAC**: if the claim contains a 6-digit certification number reported in the proper field or segment (as specified above) but such number does not correspond to number specified in MQSA file for facility, deny claim.	1/1/18 Screening: 77063 77067 1/1/18 Diagnostic: 77065 77066 G0279	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	15.20 15.20	171 film/dig 171 film/dig	N92 dig N110 film
26	**Part B**	**CWF:** 1 **screening (baseline)** mammogram asymptomatic female over 34 under 40.	1/1/18 Screening: 77063 77067	1 **screening** (baseline) mammogram asymptomatic female >34 <40	n/a	n/a	n/a	n/a	18.6	119	M89
27	**Part B**	**CWF**: over 39, 1 **screening** mammogram after at least 11 months following month last screening performed.	1/1/18 Screenung: 77063 77067	>39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	18.12 option 18.4	119	M90

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
28	**Part B**	Assign physician specialty code 45 to facilities that are certified to perform only **screening** mammography.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	45	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
29	**Part B**	**CWF** will not edit for POS for screening mammography. Disable 76X1 edit.	1/1/18 Screening: 77063 77067	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	n/a	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63
30	**Part B**	**B/MAC**: ensure that physicians who bill professional component separately use HCPCS modifier -26. Ensure that entities that bill for technical component use only HCPCS modifier -TC.	1/1/18 Screening: 77063 77067 1/1/18 Diagnostic: 77065 77066 G0279	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	26 TC	n/a	15.20 18.6	B15	N386
31	**Part B**	**B/MAC**: if screening and dx mammogram are performed on same DOS modifier -GG is required.	1/1/18 Screening: 77063 77067 1/1/18 Diagnostic: 77065 77066 G0279	1 **screening** mammogram asymptomatic female >34 <40. >39=1 screening mammogram after at least 11 months following month of last screening	n/a	n/a	GG: this modifier applies to dx codes only	n/a	15.20 15.4 15.6 18.12 18.3 18.4 18.6	7 11 50 119 151 167	MA64 M89 N435 MA63

	A	B	C	D	E	F	G	H	I	J	K
1	**NCD:**	220.4									
2	**NCD Title:**	Mammograms (CR2632, CR5050, CR5327, CR8197, CR8874, CR7501, CR9540, CR9861, CR9982, CR10086, CR10318, CR10473, CR11005)									
3	**IOM:**	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&									
4	**MCD:**	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf									
32		**B/MACs** effective DOS 1/1/18, shall accept add-on HCPCS G0279 when billed with CPT 77065 and 77066.	1/1/18 Diagnostic: G0279 77065 77066	n/a	n/a	n/a	n/a	n/a	15.20 15.4	11 50 107 167 B15	N386
33											
34	**Revision History**	According to CORE, the following CARC codes have expired: 11, 107 and 151, the following RARC codes have expired: N435, N465 and M64 **CR7501/CR9540:** Add CPT 77063 as add-on code to HCPCS G0202 effective for claims with DOS on and after 1/1/2015. **CR9540:** Remove RARC M15 from NCD220.4. **CR7501/CR9540**: Add HCPCS G0279 as add-on code to G0204 or G0206. **CR9861:** Remove ICD-10 dx code N61 not appropriate for billing - use N61.0 or N61.1 effective 10/1/16. Add reference to FISS RC 59172/59173, MCS edit 051L. Change RARC M64 to MA64, M90 to N435, N435 to MA63 in rows 7, 9, 10, 14, 15, 18, 25, 27, 34, 35, 36, 38. Change RARC M37 to M89 in row 11. Remove RARC M64 & M67, add B15 & N386 to rows 19, 20, 21, 39, 40, 41. Change M64 to MA63, M67 to N30, M89 to MA66, remove N465 in rows 26, 29, 30, 37 to adhere to CORE. CPT 77051, 77052, 77055, 77056, 77057 expire 12/31/16. Effective 1/1/17 use HCPCS G0202, G0204, G0206. These specific CPT edits will not be implemented by FISS in CR9861. FISS will implement them in CR9982 in 7/17. **CR9982:** Remove lines 13, 14, 15, 19, 24, 29, 31, 33 that corresponded to rules for expired CPT codes 77051, 77052, 77055, 77056, 77057. Remove ICD-9 codes from spreadsheet. Add ICD-10 dx Z86.000 effective 1/1/17. FISS to end-date RCs 31838, 36429, 32016 effective 10/1/15 to allow RCs 59172, 59173, 59186, 59187 to assign for ICD-10 claims. MCS 051L. **CR10086:** Add TOB 71X, 77X to align with appropriate billing criteria. (FISS RC 59186-59187, 59172-59173. No changes needed to MCS 050L, 051L, 061L). Remove ICD-9 codes from spreadsheet. Change messages on lines 11,12,13,24,25,26 to adhere to CORE. **CR10318:** Add ICD-10 dx : N63.11-N63.14, N63.21-N63.24, N63.31, N63.32, N63.41, N63.42 effective 10/1/17. End-date procedure codes G0202, G0204, and G0206 effective December 31. 2017. Add replacement CPT codes 77067, 77066, and 77065 effective January 1, 2018 (MCS 050L, 051L). End-date ICD-10 dx N63 effective 9/30/17. Correct transposed CPT codes 77065 and 77067 throughout spreadsheet narrative **CR11005** – Add ICD-10 codes N63.10 and N63.20 unspecified quadrant, effective 10/1/18. NOTE: Dual dx codes depicting specific quadrants can be reported instead of unspecified quadrants if found more appropriate by provider.									

NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R48NCD.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

ICD-9-CM	ICD-9 DX Description	ICD-10 CM	ICD-10 DX Description
	Beginning October 1, 2015, ICD-9 codes are no longer valid for processing Medicare claims.		**CMS reserves the right to add or remove codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy**
		PAP High Risk every year	
		Z77.9	Other contact with and (suspected) exposures hazardous to health
		Z91.89	Other specified personal risk factors, not elsewhere classified
		Z92.89	Personal history of other medical treatment
		Z77.29	Contact with and (suspected) exposure to other hazardous substances
		Z72.51	High risk heterosexual behavior
		Z72.52	High risk homosexual behavior
		Z72.53	High risk bisexual behavior
		PAP Low Risk every 2 years	
		Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
		Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
		Z12.4	Encounter for screening for malignant neoplasm of cervix
		Z12.72	Encounter for screening for malignant neoplasm of vagina
		Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
		Z12.89	Encounter for screening for malignant neoplasm of other sites
		Pelvic Exam	
		Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
		Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
		Z12.4	Encounter for screening for malignant neoplasm of cervix
		Z12.72	Encounter for screening for malignant neoplasm of vagina
		Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
		Z12.89	Encounter for screening for malignant neoplasm of other sites
		Z72.51	High risk heterosexual behavior
		Z72.52	High risk homosexual behavior
		Z72.53	High risk bisexual behavior
		Z77.9	Other contact with and (suspected) exposures hazardous to health
		Z91.89	Other specified personal risk factors, not elsewhere classified
		Z92.89	Personal history of other medical treatment
		Z77.29	Contact with and (suspected) exposure to other hazardous substances

NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

ICD-9	ICD-9 Px Description	ICD-10 PCS	ICD-10 PCS Description
N/A	N/A	N/A	N/A

NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MACs & CWF:** To be covered screening Pap smears must be ordered and collected by a doctor of medicine or osteopathy (as defined in §1861(r)(l) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under one of the conditions identified in §30.1, below. If the beneficiary does not qualify for more frequent screening for services performed on or after July 1, 2001, payment may be made for a screening PAP smear after 2 years/23 months have passed following the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	Every 2 years /23 months have passed following the month of the last covered smear	12X 13X 22X 23X 85X	0311	N/A	N/A	18.17	119	M83 N362
Part A	**A/MACs & CWF:** 2. There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 2 years. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high risk, 11 months have passed following the month of the last smear, and 1 every 2 years for low risk, 23 months have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362

NCD:	210.2									
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part A	**A/MACs & CWF:** 3. She is at high risk of developing cervical or vaginal cancer and at least I year/11 months have passed following the month that the last covered screening Pap smear was performed. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year/11 months have passed following the month of the last covered screening Pap smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part A	**A/MACs & CWF:** If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, for services performed on or after 7/7/01, payment may be made for a screening PAP smear every 2 years/23 months have passed following the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every 2 years /23 months have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part A	The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. See Chapter 9, for RHC/FQHC bill processing instructions.	P3000 G0123 G0143 G0144 G0145 G0147 G0148	1 every year for high risk (11 months have passed following the month of the last smear) and 1 every 2 years for low risk (23 months have passed following the month of the last smear)	71X 77X	052X	N/A	N/A	18.17	119	M83 N362

NCD:	210.2									
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
	CWF: CMS has determined that the screening pelvic/clinical breast examination, HCPCS G0101 and screening Papanicolaou smear, HCPCS Q0091, are billable visits when furnished by a RHC or FQHC practitioner to a RHC or FQHC patient. These services will be paid the AIR on RHC and FQHC claims effective for dates of service on or after 1/1/14. If other billable visits are furnished on the same DOS as G0101 or Q0091, only one visit shall be paid. G0101 or Q0091 are payable annually for women at high risk for developing cervical or vaginal cancer, and women of childbearing age who have had an abnormal Pap test within the past 2 years. It is payable every 2 years/23 months have passed following the month of the last covered smear for women at normal risk. For FQHCs billing under the PPS, G0101 and Q0091 are qualifying visits when billed with FQHC payment HCPCS codes G0466 or G0467. Contractors shall add HCPCS codes G0101 & Q0091 to the list of preventive services eligible to be paid at the AIR for 71X & 77X TOBs. NOTE: Payment for G0101 & Q0091 should be effective for DOS on or after 1/1/14. Contractors shall prevent a separate payment when G0101 or Q0091 is billed on the same DOS as an encounter/visit with revenue code 052X (This does not apply to IPPE for RHC & FQHC claims and FQHC claims with DSMT, MNT or modifier 59).	G0101 Q0091	1 every year for high risk (11 months have passed) and 1 every 2 years for low risk (23 months have pased.)	71X 77X	052X	N/A	N/A	16.34	97	M15
Part A	**A/MACs:** If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/MACs under TOB as appropriate using their OP provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). Use appropriate revenue code. Effective 4/1/06 TOB 14X is for non-patient laboratory specimens. If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed contractors use: When an A/MAC receives a claim for a screening pelvic examination (including a clinical breast examination), performed on or after 1/1/98, it reports special override Code 1 in the Special Action Code/Override Code field of the CWF record for the line item, indicating the Part B deductible does not apply. CWF edits for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091 or G0101	1 every year for high risk /11 months have passed following the month of the last smear and 1 every 2 years for low risk/23 months have passed following the month of the last smear	13X 22X 23X 85X	0311	N/A	N/A	18.17	119	M83 N362

NCD:	210.2									
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part A	**CWF:** will edit for claims containing HCPCS code Q0091 effective 7/1/05. Previously, the editing for Q0091 had been removed from CWF. Medicare pays for a screening Pap smear every 2 years for low-risk patients based on a low-risk dx, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high-risk patient based on the hig- risk dx, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing Q0091. In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the physician should annotate the claim with Q0091 along with modifier -76, (repeat procedure by same physician).	Q0091	1 every year for high-risk, 11 months have passed following the month of the last smear, and 1 every 2 years for low-risk, 23 months have passed following the month of the last smear	N/A	N/A	76	N/A	18.17	119	M83 N362
Part A	Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B. In addition, CAHs electing method II report professional services under revenue codes:	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high risk /11 months have passed following the month of the last smear, and 1 every 2 years for low risk /23 months have passed following the month of the last smear	12X 13X 22X 23X 85X	096X 097X 098X	N/A	N/A	18.17	119	M83 N362
Part A	**A/MACs & CWF:** If the technical component of a screening pelvic examination is furnished within a provider-based **RHC/FQHC**, the provider of that service bills the A/MAC under TOB & OP provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). CWF will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high-risk factors.	G0101	1 every year/11 months have passed following the month of the last smear	71X 73X	052X	N/A	N/A	18.17	119	M83 N362

NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MACs & CWF:** To be covered screening Pap smears must be ordered/collected by a doctor of medicine or osteopathy (as defined in §1861(r)(l) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under one of the conditions identified in §30.1, below. If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, for services performed on or after 7/7/01, payment may be made for a screening pelvic examination after2 years/ 23 months have passed following the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	Every 2 years/23 months passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** 2. There is evidence (on the basis of medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 2 years: If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high risk /11 months have passed following the month of the last smear. and 1 every 2 years for low risk /23 months have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362

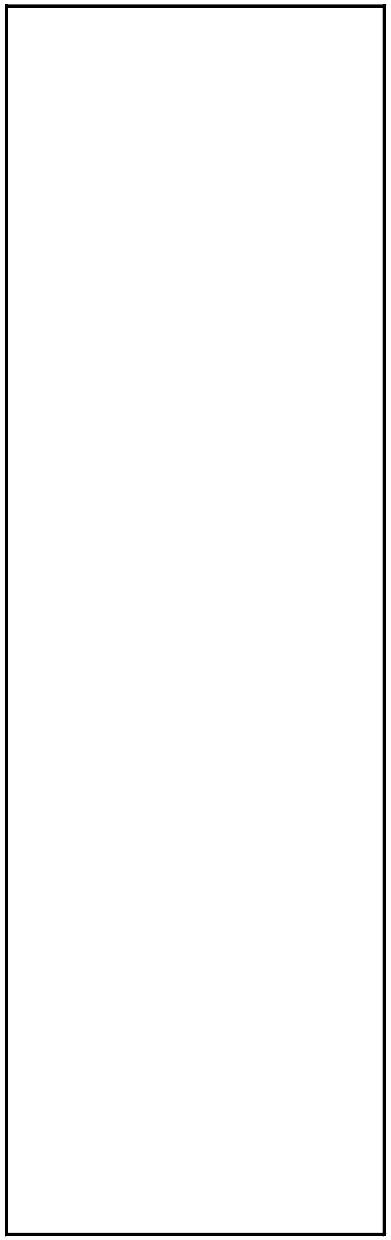
NCD:	210.2									
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part B	**B/MACs & CWF:** 3. She is at high risk of developing cervical or vaginal cancer and at least 1 year/11 months have passed following the month that the last covered screening Pap smear was performed. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year/11 months have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, effective 7/101, payment may be made for a screening PAP smear after 2 years or 23 months have passed following the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every 2 years/23 month have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**CWF** will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high-risk factors	G0101	1 every year/11 months have passed following the month of the last smear	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** Payment for Q0091 is paid under the Medicare physician fee schedule. Deductible is not applicable, coinsurance applies. Effective 7/1/05, on those occasions when physicians must perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low-risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will be denied appropriately. The physician shall obtain an ABN in these situations as the denial will be considered an R&N denial. Effective 4/1/99, a covered E/M visit and code Q0091 may be reported by the same physician for the same DOS if the E/M visit is for a separately identifiable service. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	Q0091	1 every 2 years/23 month have passed following the month of the last smear	N/A	N/A	Denial - GA E/M - 25	N/A	18.17	119	M83 N362

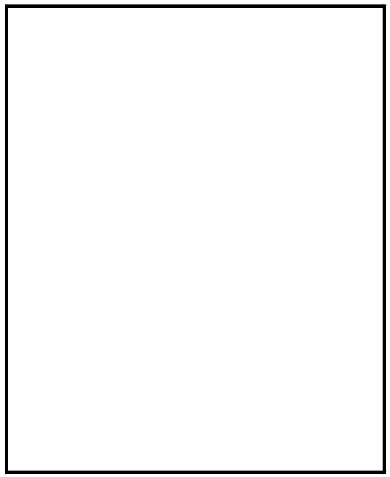
NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer (CR8691, CR9252, CR11005)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1434OTN.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&
	REVISION HISTORY
	As suggested added 1 every 3 years for high-risk, 1 every 2 years for low-risk and removed varies by dx. Changed every 3 years to 3 years passed since last covered test because the former statement is less clear about what the NCD is stating. Changed all Message Codes to the ones that are listed in the CPM. CARC/RARC combination is valid.
	Added suggested RARCs all Message Codes are Core compliant. Dx codes Z77.22, Z77.9, Z91.89, V15.89 were removed. Added If Pap smear claims do not point to one of the specific dx in Item 24E or the electronic equivalent, the claim will reject in the CWF.
	CR8691: Added CWF is currently performing and will continue to perform all frequency editing for this NCD. FISS removed RCs 59162/59163.
	Removed all references to N390 because it is not core compliant to CARC 119.
	Added MAC designations and billing instructions from CR 8927 for RHCs and FQHCs.
	As per comments made by WPS added ICD-9 Dx code V15.89 back to Dx tab for hi-risk pap and pelvic exams (not valid for ICD-10).
	CR9252: Per WPS, added ICD-10 dx codes Z77.9, Z91.89, Z92.89, Z77.29 to denote high risk indications associated with pap smears.
	Removed FISS from line item 12 at its request to align with removal of RCs 59162/59163 in CR8691.
	CR11005: Effective 10/1/15 screening PAP smears and pelvic examinations can be performed every 2 years or 23 months have passed following the month of the last covered smear/exam. Removed ICD-9 coding. FISS to create new 59CXX RCs to allow denial of CWF RCs 5612/5616 when frequency has been exceeded. MACs to either manually or with ECPS apply new 59CXX RCs when CWF edit is received to ensure benefit savings are properly captured. Denial messages are as follows: CARC 119, RARC M83 or N362, MSN 18.17, CO and PR as appropriate.

NCD:	20.7
NCD Title:	Percutaneous Transluminal Angioplasty (PTA)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&

		ICD-10 CM	ICD-10 DX Description
Indications for PTA of the Carotid Artery Concurrent with Stenting (must bill one of these primary codes to meet coverage under 20.7B2, 20.7B3, 20.7B4)			
		I63.031	Cerebral infarction due to thrombosis of right carotid artery
		I63.032	Cerebral infarction due to thrombosis of left carotid artery
		I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries
		I63.131	Cerebral infarction due to embolism of right carotid artery
		I63.132	Cerebral infarction due to embolism of left carotid artery
		I63.133	Cerebral infarction due to embolism of bilateral carotid arteries
		I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries
		I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries
		I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries
		I65.21	Occlusion and stenosis of right carotid artery
		I65.22	Occlusion and stenosis of left carotid artery
		I65.23	Occlusion and stenosis of bilateral carotid arteries
Indications for PTA and Stenting of Intracranial Arteries (must bill I67.2 and one of these primary codes to meet coverage under 20.7B5)			
		I67.2	Cerebral atherosclerosis
		I66.01	Occlusion and stenosis of right middle cerebral artery
		I66.02	Occlusion and stenosis of left middle cerebral artery
		I66.03	Occlusion and stenosis of bilateral middle cerebral arteries
		I66.11	Occlusion and stenosis of right anterior cerebral artery
		I66.12	Occlusion and stenosis of left anterior cerebral artery
		I66.13	Occlusion and stenosis of bilateral anterior cerebral arteries
		I66.21	Occlusion and stenosis of right posterior cerebral artery
		I66.22	Occlusion and stenosis of left posterior cerebral artery
		I66.23	Occlusion and stenosis of bilateral posterior cerebral arteries
		I66.8	Occlusion and stenosis of other cerebral arteries
		I63.59	Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery
Claims must include codes from the lists as noted above. This does not preclude the inclusion of additional codes specific to each procedure. Z00.6 must be appended to claims for clinical trials covered under this policy as described below and specified in NCD 20.7.			
For Clinical Trial Billing (clinical trial participation required for all claims under 20.7B2, 20.7B3, 20.7B5, and 20.7B4 only when patients are high risk for CEA and symptomatic with 50-70% carotid artery stenosis or asymptomatic with ≥80% carotid artery stenosis)			
		Z00.6	Encounter for examination for normal comparison and control in clinical research program
For Denials			
		T85.9xxA	Unspecified complication of internal prosthetic device, implant and graft, initial encounter

		ICD-10 CM	ICD-10 DX Description	





NCD:	20.7
NCD Title:	Percutaneous Transluminal Angioplasty (PTA)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&

		ICD-10 PCS	ICD-10 PCS Description
		037H34Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037H3DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Approach
		037H44Z	Dilation of Right Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037H4DZ	Dilation of Right Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037J34Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037J3DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Approach
		037J44Z	Dilation of Left Common Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037J4DZ	Dilation of Left Common Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037K3DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
		037K34Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037K44Z	Dilation of Right Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037K4DZ	Dilation of Right Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037L34Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037L3DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Approach
		037L44Z	Dilation of Left Internal Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037L4DZ	Dilation of Left Internal Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037M34Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037M3DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Approach
		037M44Z	Dilation of Right External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037M4DZ	Dilation of Right External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach

		ICD-10 PCS	ICD-10 PCS Description
		037N34Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037N3DZ	Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Approach
		037N44Z	Dilation of Left External Carotid Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037N4DZ	Dilation of Left External Carotid Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037H346	Dilation of Right Common Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037H356	Devices, Percutaneous Approach
		037H35Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037H366	Dilation of Right Common Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037H36Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037H376	Intraluminal Devices, Percutaneous Approach
		037H37Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037H3D6	Percutaneous Approach
		037H3E6	Dilation of Right Common Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037H3EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037H3F6	Dilation of Right Common Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037H3FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037H3G6	Dilation of Right Common Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037H3GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037H446	Dilation of Right Common Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037H456	Dilation of Right Common Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H45Z	Dilation of Right Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H466	Dilation of Right Common Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H46Z	Dilation of Right Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H476	Dilation of Right Common Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H47Z	Dilation of Right Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037H4D6	Dilation of Right Common Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037H4E6	Dilation of Right Common Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach

		ICD-10 PCS	ICD-10 PCS Description
		037H4EZ	Dilation of Right Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037H4F6	Dilation of Right Common Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037H4FZ	Dilation of Right Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037H4G6	Dilation of Right Common Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037H4GZ	Dilation of Right Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037J346	Dilation of Left Common Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037J356	Dilation of Left Common Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J35Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J366	Dilation of Left Common Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J36Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J376	Dilation of Left Common Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J37Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037J3D6	Dilation of Left Common Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach
		037J3E6	Dilation of Left Common Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037J3EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037J3F6	Dilation of Left Common Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037J3FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037J3G6	Dilation of Left Common Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037J3GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037J446	Dilation of Left Common Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037J456	Dilation of Left Common Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037J45Z	Dilation of Left Common Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037J466	Dilation of Left Common Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037J46Z	Dilation of Left Common Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037J476	Dilation of Left Common Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach

		ICD-10 PCS	ICD-10 PCS Description
		037J47Z	Dilation of Left Common Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4D6	Dilation of Left Common Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037J4E6	Dilation of Left Common Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4EZ	Dilation of Left Common Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4F6	Dilation of Left Common Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4FZ	Dilation of Left Common Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4G6	Dilation of Left Common Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037J4GZ	Dilation of Left Common Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037K346	Dilation of Right Internal Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037K356	Dilation of Right Internal Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K35Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K366	Dilation of Right Internal Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K36Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K376	Dilation of Right Internal Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K37Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037K3D6	Dilation of Right Internal Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach
		037K3E6	Dilation of Right Internal Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037K3EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037K3F6	Dilation of Right Internal Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037K3FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037K3G6	Dilation of Right Internal Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037K3GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037K446	Dilation of Right Internal Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037K456	Dilation of Right Internal Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037K45Z	Dilation of Right Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach

		ICD-10 PCS	ICD-10 PCS Description
		037K466	Dilation of Right Internal Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037K46Z	Dilation of Right Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037K476	Dilation of Right Internal Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037K47Z	Dilation of Right Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4D6	Dilation of Right Internal Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037K4E6	Dilation of Right Internal Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4EZ	Dilation of Right Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4F6	Dilation of Right Internal Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4FZ	Dilation of Right Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4G6	Dilation of Right Internal Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037K4GZ	Dilation of Right Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037L346	Dilation of Left Internal Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037L356	Dilation of Left Internal Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L35Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L366	Dilation of Left Internal Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L36Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L376	Dilation of Left Internal Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L37Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037L3D6	Dilation of Left Internal Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach
		037L3E6	Dilation of Left Internal Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037L3EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037L3F6	Dilation of Left Internal Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037L3FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037L3G6	Dilation of Left Internal Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037L3GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach

		ICD-10 PCS	ICD-10 PCS Description
		037L446	Dilation of Left Internal Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037L456	Dilation of Left Internal Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L45Z	Dilation of Left Internal Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L466	Dilation of Left Internal Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L46Z	Dilation of Left Internal Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L476	Dilation of Left Internal Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L47Z	Dilation of Left Internal Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4D6	Dilation of Left Internal Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037L4E6	Dilation of Left Internal Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4EZ	Dilation of Left Internal Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4F6	Dilation of Left Internal Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4FZ	Dilation of Left Internal Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4G6	Dilation of Left Internal Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037L4GZ	Dilation of Left Internal Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037M346	Dilation of Right External Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037M356	Dilation of Right External Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M35Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M366	Dilation of Right External Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M36Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M376	Dilation of Right External Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M37Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037M3D6	Dilation of Right External Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach
		037M3E6	Dilation of Right External Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037M3EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037M3F6	Dilation of Right External Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach

		ICD-10 PCS	ICD-10 PCS Description
		037M3FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037M3G6	Dilation of Right External Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037M3GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037M446	Dilation of Right External Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037M456	Dilation of Right External Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M45Z	Dilation of Right External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M466	Dilation of Right External Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M46Z	Dilation of Right External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M476	Dilation of Right External Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M47Z	Dilation of Right External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4D6	Dilation of Right External Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037M4E6	Dilation of Right External Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4EZ	Dilation of Right External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4F6	Dilation of Right External Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4FZ	Dilation of Right External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4G6	Dilation of Right External Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037M4GZ	Dilation of Right External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037N346	Dilation of Left External Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach
		037N356	Dilation of Left External Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N35Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N366	Dilation of Left External Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N36Z	Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N376	Dilation of Left External Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N37Z	Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037N3D6	Dilation of Left External Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach

		ICD-10 PCS	ICD-10 PCS Description
		037N3E6	Dilation of Left External Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037N3EZ	Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Approach
		037N3F6	Dilation of Left External Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037N3FZ	Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Approach
		037N3G6	Dilation of Left External Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037N3GZ	Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037N446	Dilation of Left External Carotid Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037N456	Dilation of Left External Carotid Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N45Z	Dilation of Left External Carotid Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N466	Dilation of Left External Carotid Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N46Z	Dilation of Left External Carotid Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N476	Dilation of Left External Carotid Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N47Z	Dilation of Left External Carotid Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4D6	Dilation of Left External Carotid Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037N4E6	Dilation of Left External Carotid Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4EZ	Dilation of Left External Carotid Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4F6	Dilation of Left External Carotid Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4FZ	Dilation of Left External Carotid Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4G6	Dilation of Left External Carotid Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037N4GZ	Dilation of Left External Carotid Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037G34Z	Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Approach
		037G3DZ	Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Approach
		037G44Z	Dilation of Intracranial Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037G4DZ	Dilation of Intracranial Artery with Intraluminal Device, Percutaneous Endoscopic Approach
		037G346	Dilation of Intracranial Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Approach

		ICD-10 PCS	ICD-10 PCS Description
		037G356	Dilation of Intracranial Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G35Z	Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G366	Dilation of Intracranial Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G36Z	Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G376	Dilation of Intracranial Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G37Z	Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Approach
		037G3D6	Dilation of Intracranial Artery, Bifurcation, with Intraluminal Device, Percutaneous Approach
		037G3E6	Dilation of Intracranial Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Approach
		037G3EZ	Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Approach
		037G3F6	Dilation of Intracranial Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Approach
		037G3FZ	Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Approach
		037G3G6	Dilation of Intracranial Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Approach
		037G3GZ	Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Approach
		037G446	Dilation of Intracranial Artery, Bifurcation, with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach
		037G456	Dilation of Intracranial Artery, Bifurcation, with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G45Z	Dilation of Intracranial Artery with Two Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G466	Dilation of Intracranial Artery, Bifurcation, with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G46Z	Dilation of Intracranial Artery with Three Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G476	Dilation of Intracranial Artery, Bifurcation, with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G47Z	Dilation of Intracranial Artery with Four or More Drug-eluting Intraluminal Devices, Percutaneous Endoscopic Approach
		037G4D6	Dilation of Intracranial Artery, Bifurcation, with Intraluminal Device, Percutaneous Endoscopic Approach
		037G4E6	Dilation of Intracranial Artery, Bifurcation, with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037G4EZ	Dilation of Intracranial Artery with Two Intraluminal Devices, Percutaneous Endoscopic Approach
		037G4F6	Dilation of Intracranial Artery, Bifurcation, with Three Intraluminal Devices, Percutaneous Endoscopic Approach
		037G4FZ	Dilation of Intracranial Artery with Three Intraluminal Devices, Percutaneous Endoscopic Approach

		ICD-10 PCS	ICD-10 PCS Description
		037G4G6	Dilation of Intracranial Artery, Bifurcation, with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach
		037G4GZ	Dilation of Intracranial Artery with Four or More Intraluminal Devices, Percutaneous Endoscopic Approach

NCD:	20.7
NCD Title:	Percutaneous Transluminal Angioplasty (PTA) (CR3811, CR8197 CR8691, CR9252, CR9631, CR9751, CR11005)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MACs:** Effective 7/1/01, covers PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved- protocols governing Category B IDE clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, is considered to be R&N when provided in the context of such a clinical trial.	See ICD Procedure Tab	N/A	N/A	N/A	Q0 Q1 FB	N/A	16.77	16	MA50
Part A	As a requirement for Category B IDE coverage, providers must bill a 6-digit IDE Number that begins with a “G” (i.e., G123456). To identify the line as an IDE line, institutional providers must bill this IDE Number on a 0624 Revenue Code	N/A	N/A	N/A	0624	N/A	N/A	16.77	16	M50
Part A	**A/MACs:** Effective 10/12/04, covers PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent and an FDA-approved or -cleared embolic protection device (effective 12/9/09) for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies. CMS determines that coverage of PTA of the carotid artery is R&N in these circumstances	See ICD Procedure Tab	N/A	N/A	N/A	Q0	N/A	16.77	16	MA50
Part A	**A/MACs:** Effective 3/17/05, Shall pay claims that contain the following for beneficiaries that meet the high risk criteria listed under the policy section of this instruction and in Pub 100-03, chapter 1, section 20.7B4. MCS edit 037L remains. **NOTE:** Procedures that are not performed in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (NCD310.1), or in accordance with the NCD on (CAS) post-approval studies (NCD20.7) must be performed in approved CAS facilities. A list of approved facilities is available/viewable at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Carotid-Artery-Stenting-Facilities.html	See ICD Procedure Tab								

NCD:	20.7									
NCD Title:	Percutaneous Transluminal Angioplasty (PTA) (CR3811, CR8197 CR8691, CR9252, CR9631, CR9751, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&									
Part A	Providers of covered intracranial PTA with stenting shall use Category B IDE billing requirements providers must bill the appropriate procedure and dx codes to receive payment. Under Part A, providers must bill intracranial PTA using ICD procedure codes along with dx I67.2. **NOTE:** Part A edit 59118/59119 should use procedure code as trigger and NOT dx I67.2.	See ICD Procedure Tab	N/A	N/A	N/A	Q0 Q1 FB	N/A	9.2 16.77	16	M64
Part A	**A/MACs:** Deny services for patients at high risk if the appropriate dx & procedure codes are not on the claim. The use of an FDA-approved or cleared embolic protection device is required. If deployment of the embolic protection device is not technically possible, and not performed, then the procedure is not covered by Medicare	See ICD Procedure Tab	N/A	N/A	N/A	N/A	N/A	9.2	16	MA128
Part A	Providers of covered intracranial PTA with stenting shall use Category B IDE billing requirements providers must bill the appropriate procedure & dx codes to receive payment. Providers must bill ICD-10 procedure code along with dx I67.2. See line 10 Note.	See ICD Procedure Tab	N/A	N/A	N/A	Q0 Q1 FB	N/A	9.2 16.77	16	M64
Part A	**FISS:** Deny claims with 996.70/T85.9xxA, pay all claims for high risk indications, clincal trials, and covered intracranial PTA with stenting. **NOTE:** Policy is finite that any indication for PTA w/or w/o stenting to treat obstructive lesions of vertebral/cerebral arteries are NON-COVERED. Any indication for PTA w/o stenting not specifically indicated in NCD20.7 is NON-COVERED. Any indication for PTA w/stenting not specifically indicated in NCD20.7 is left to contractor discretion.	See ICD Procedure Tab	N/A	N/A	N/A	N/A	N/A	9.2 16.77	16	M64

NCD:	20.7
NCD Title:	Percutaneous Transluminal Angioplasty (PTA) (CR3811, CR8197 CR8691, CR9252, CR9631, CR9751, CR11005)
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**MCS & B/MACs:** Effective 7/1/01, covers PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved- protocols governing Category B IDE clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, is considered to be R&N when provided in the context of such a clinical trial.	37215	N/A	N/A	N/A	Q0 Q1 FB	N/A	16.77	16	MA50
Part B	As a requirement for Category B IDE coverage, providers must bill a 6-digit IDE Number that begins with a "G" (i.e., G123456) practitioners must bill this IDE Number along with a -Q0 modifier.	N/A	N/A	N/A	N/A	Q0 Q1 FB	N/A	16.77	16	M50
Part B	**B/MACs:** Effective 10/12/04, covers PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent and an FDA-approved or -cleared embolic protection device (effective 12/9/09) for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies. CMS determines that coverage of PTA of the carotid artery is R&N in these circumstances.	37215	N/A	N/A	N/A	Q0 Q1 FB	N/A	16.77	16	MA50
Part B	**B/MACs:** Effective 3/17/05, Shall pay claims that contain the following for beneficiaries that meet the high risk criteria listed under the policy section of this instruction and in Pub 100-03, chapter 1, section 20.7B4. MCS edit 037L remains. **NOTE**: Procedures that are not performed in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (NCD310.1), or in accordance with the NCD on (CAS) post-approval studies (NCD20.7) must be performed in approved CAS facilities. A list of approved facilities is available/viewable at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Carotid-Artery-Stenting-Facilities.html.									
Part B	Providers of covered intracranial PTA with stenting shall use Category B IDE billing requirements, ~~,~~ providers must bill the appropriate procedure & dx codes to receive payment. Under Part B, providers must bill procedure code 37799 along with dx I67.2.	37799	N/A	N/A	N/A	Q0 Q1 FB	N/A	9.2 16.77	16	M64

NCD:	20.7									
NCD Title:	Percutaneous Transluminal Angioplasty (PTA) (CR3811, CR8197 CR8691, CR9252, CR9631, CR9751, CR11005)									
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf									
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&									
Part B	If the device has not been submitted to the FDA for approval; if it has a category A classification;or it has category B classification; or it is part of a post-market approval study, and has not been approved by the appropriate Medical Directors in writing, indicate this with use of ICD-10 code T85.9xxA. Place this ICD-10 code in position 1 on Box 21 of the 1500 form to receive the appropriate, non-covered denial. No other ICD-10 code should be listed in order to receive a non-covered denial.	37215	N/A	N/A	N/A	N/A	N/A	14.9	96	N569
Part B	**B/MACs:** Deny services for patients at high risk if the appropriate dx & procedure codes are not on the claim. The use of an FDA-approved or -cleared embolic protection device is required. If deployment of the embolic protection device is not technically possible, and not performed, then the procedure is not covered by Medicare.	37215	N/A	N/A	N/A	N/A	N/A	9.2	16	MA128
Part B	**MCS:** Deny claims with T85.9xxA. Pay all claims for high risk indications, clincal trials, covered intracranial PTA with stenting. MCS edit 058L. NOTE: Policy is finite that any indication for PTA w/or w/o stenting to treat obstructive lesions of vertebral/cerebral arteries are NON-COVERED. Any indication for PTA w/o stenting not specifically indicated in NCD20.7 is NON-COVERED. Any indication for PTA w/stenting not specifically indicated in NCD20.7 is left to contractor discretion.	37215 37799	N/A	N/A	N/A	N/A	N/A	9.2 16.77	16	M64

Revision Date	Revision History
	Revise to add high risk patient information.
	ADD RARC N386. "No other ICD-10 code" noted in spreadsheet. Add procedure 37799 to A/MAC billing. No MCS SSM-controlled edit is needed for procedure 37799 since this is a NOC code which could have other uses outside of this NCD policy. Per MM5667, CR5667, 6/15/13, claims submitted by physicians to MACs may also contain CPT 37215, 0075T, or 0076T. Claims submitted by institutional providers to MACs should contain the appropriate PCS codes 00.61 and 00.63.
	Add FISS & MCS denial of T85.9xxA, payment of high risk indications, clincal trials, covered intracranial PTA with stenting.
	Remove references to 37799 in Part A instructions. Change "To be billed with IP procedure codes or 37799 for Part B billing" to "To be billed with IP procedure Codes for A/MAC or 37799 for B/MAC billing" on ICD-10 dx tab Remove RARCN386 with CARC251 for CORE compliance.
	CR9252: Remove NOC codes I65.29, I63.039, I63.139, I63.239 per Palmetto.
	Change all instances of CARC 251 and RARC M64 to CARC 16 and RARC M64 to make the combination CORE compliant.
	Add ICD procedure codes 00.61 and 00.63. Note in line 10 that Part A edit 59118/59119 should use procedure code as trigger and NOT I67.2.
	CR9631:Add requested ICD-10 codes I63.3, I63.4 and I66. Remove 51 ICD procedure codes including 8 Extripation ones effective 10/1/15. See comment. Edits included in CR9631.
	Remove reference to effective date of 7/1/01 for cells B7 and B16 and replace with updated clinical trial information as listed in CR6839.

NCD:	20.7				
NCD Title:	Percutaneous Transluminal Angioplasty (PTA) (CR3811, CR8197 CR8691, CR9252, CR9631, CR9751, CR11005)				
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1925CP.pdf				
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=AgAAgAAAAAAA&				
	Rules Description updated. mapping clarified and duplicative procedure codes removed. removed effective 10/1/15.				ICD procedure 0075T, 0076T

NCD:	230.18
NCD Title:	Sacral Nerve Stimulation For Urinary Incontinence
IOM:	https://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=249&ncdver=1&DocID=230.18&SearchType=Advanced&bc=IAAAAAgAAAAA&

		ICD-10 CM	ICD-10 DX Description
		R33.9	Retention of urine, unspecified
		R35.0	Frequency of micturition
		R39.11	Hesitancy of micturition
		R39.14	Feeling of incomplete bladder emptying
		R39.15	Urgency of urination
		N39.41	Urge incontinence
		N39.46	Mixed incontinence

NCD:	230.18		
NCD Title:	Sacral Nerve Stimulation For Urinary Incontinence		
IOM:	https://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf		
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=249&ncdver=1&DocID=230.18&SearchType=Advanced&bc=IAAAAAgAAAAA&		
		ICD-10	**ICD-10 PCS Description**
		N/A	N/A

NCD:	230.18
NCD Title:	Sacral Nerve Stimulation For Urinary Incontinence (CR1881, CR1936, CR2532, CR9540, CR9751, CR11005)
IOM:	https://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=249&ncdver=1&DocID=230.18&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**FISS & A/MACs:** Effective 1/1/02, shall allow edit for CPT/HCPCS with approved dx. SNS is covered for tx of urinary urge incontinence, urgency-frequency syndrome, and urinary retention. The TC is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills their A/MAC on Form CMS-1500 or electronic equivalent. The TC for a provider-based RHC/FQHC is typically furnished by the provider. The provider of the service bills you as appropriate using their OP provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). RCs for the implantation can be performed in a number of revenue centers within a hospital such as operating room (360) or clinic (510). Therefore, instruct your hospitals to report these implantation procedures under the revenue center where they are performed.	64585 64590 64595	N/A	13X 14X 71X 73X 75X 85X	920 except for RHCs/FQHCs who report under revenue code 521	N/A	N/A	15.20 15.4 21.21	96	N386 N569
Part A	**FISS & A/MACs:** shall allow edit for CPT/HCPCS for **implantation procedures** with approved dx. **Revenue codes** for implantation can be performed in a number of revenue centers within a hospital such as operating room (360) or clinic (510). Therefore, instruct your hospitals to report these implantation procedures under the revenue center where they are performed.	64561 64581		11X 13X 85X	under the revenue center where they are performed	N/A	N/A	15.20 15.4 21.21	96	N386 N529
Part A	**A/MACs:** shall allow edit for CPT/HCPCS for sacral nerve stimulator **devices** with approved dx.	C1767 C1778 C1883 C1897	N/A	11X 13X 85X	276, 278, 279, 280, 289, 290 or 624 as appropriate	N/A	N/A	15.20 15.4 21.21	96	N386 N529
Part A	**A/MACs:** shall ensure CPT codes 95970, 95971, and 95972 are included in all related, existing edits effective for claims with dates of service on and after 10/1/15. (This will eliminate discrepany with NCDs 160.18 & 160.24).	95971 95972 95970	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part A	The applicable **bill types** for implantation procedures and devices are as follows: The applicable **revenue code** for device codes A4290 provided in a CAH is as follows:	A4290	N/A	11X 13X 85X	provided in a CAH = 290	N/A	N/A	15.20 15.4 21.21	170=TOB 16=revenue	N/A M50

NCD:	230.18
NCD Title:	Sacral Nerve Stimulation For Urinary Incontinence (CR1881, CR1936, CR2532, CR9540, CR9751, CR11005)
IOM:	https://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=249&ncdver=1&DocID=230.18&SearchType=Advanced&bc=IAAAAAgAAAAA&

Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MACs**: shall ensure CPT 95970, 95971, 95972 are included in related, existing edits effective for claims with DOS on and after 10/1/15. (This will eliminate discrepany with NCDs 160.18 & 160.24).	95970 95971 95972	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Part B	**B/MACs:** Effective 1/1/02, shall allow edit for CPT/HCPCS for SNS procedures with approved dx. Applicable ASC procedures are 64590, 64595. A4290 should be added to CWF categories 03 (prosthetics/orthotics) and 67 (local carrier jurisdiction). NOTE: 64581, 54561, A4290 also in NCDs 160.2 & 160.7.	64561 64581 64585 64590 64595 A4290	N/A	N/A	N/A	N/A	N/A	15.20 15.4 21.21	11 50 167	M76 N386