CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13251	**Date: June 6, 2025**
	Change Request 14041

SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - October 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a quarterly maintenance update of ICD-10 coding conversions and other coding updates specific to NCDs. No policy is being changed as a result of these updates.

EFFECTIVE DATE: October 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 8, 2025 - BR 14041.2 and BR 14041.4; October 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 13251	Date: June 6, 2025	Change Request: 14041

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II. GENERAL INFORMATION

A. Background: The purpose of this CR is to provide 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/determination-process/basics/icd-10 along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process.

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/CR14041.zip

Clarification: Coding (as well as payment) is a separate and distinct area of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Note: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs)* mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. *GEMs mapping is no longer provided by CMS as of October 1, 2019. In addition, for those policies that expressly allow Medicare Administrative Contractor (MAC) discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

Note/Clarification: A/B MACs Part A and A/B MACs Part B shall complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

Note/Clarification: A/B MACs shall use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update. When denying claims associated with the attached NCDs, except where otherwise indicated, A/B MACs shall use: Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file). Group Code Contractual Obligation (CO) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and Medicare Summary Notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14041.1	NCD 190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management Contractors shall note the correction to the revision notes from CR 13828. The correct the Fiscal Intermediary Shared System (FISS) reason codes for NCD 190.11 are 59079/59080. See attached spreadsheet.	X								
14041.2	NCD 110.24 CAR-T Contractors shall add new Healthcare Common Procedure Coding System (HCPCS) code Q2058 effective July 1, 2025, for Obe-cel, Aucatzl®	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Contractors shall add new HCPCS code C9301 for Obecel, Aucatzyl® for Dates of Service (DOS) April 1, 2025, to June 30, 2025. See attached spreadsheet.									
14041.3	NCD 210.4.1 Counseling to Prevent Tobacco Use Contractors shall add ICD-10 CM code Z72.0 effective October 1, 2024 to modify reason codes 59211, 59212, 59166 and 59167 to allow HCPCS 99406 and 99407, billed with revenue code 0519 on Federally Qualified Health Care (FQHC) claims (Type of Bill (TOB) 77X). The Multi-Carrier System (MCS) contractor shall update 048L. Contractors shall allow reason codes to be overridable. See attached spreadsheet.	X	X			X	X			
14041.4	NCD 20.9.1 Ventricular Assist Devices Contractors shall add ICD-10 diagnosis code Z95.811 (Presence of heart assist	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	device) effective December 1, 2020. See attached spreadsheet									
14041.5	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall pay for HCPCS code G0567 with modifier QW when billed by Clinical Laboratory Improvement Amendment (CLIA) waived laboratories, effective retroactive to the FDA approval date of the test to June 27, 2024. See attached spreadsheet		X				X			
14041.6	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Effective for claims with DOS on or after June 27, 2024, contractors shall modify current editing for Hepatitis C screening (HCV) for HCPCS code G0567. The contractor shall add HCPCS G0567 to the following Part B and Outpatient edits: • Edit 5303 Beneficiary with a DOB between 1945 through 1965 with ICD-10 diagnosis code 'Z11.59' and posted to the 'HCVS' Auxiliary file is HCPCS code 'G0472' or G0567	X	X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	(DOS after June 27, 2024). Allowed once in lifetime. • Edit 5304 – Beneficiary has an HCV screening with ICD-10 diagnosis code 'Z72.89' within 11 months. • Edit 5305 – beneficiary has an HCV screening within '11' months of a posted HCV screening with ICD-10 diagnosis code 'Z72.89' and ICD-10 'F19.20'. • Edit 5306 – beneficiary has an HCV screening without diagnosis code(s) ICD-10 'Z72.89' or ICD-10 'Z72.89' and 'F19.20' for a Beneficiary who is not high-risk and whose date of birth is prior to 1945 and after 1965. • Edits 34#2 and 34x2 – Units greater than one for HCPCS G0567.									
14041.7	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall modify the HCVS aux file in the Health Insurance Master Record (HIMR) to add HCPCS code G0567.					X			X	
14041.8	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults					X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Contractors shall modify the PRVN aux file in HIMR to add HCPCS G0567 to the HCAS group. The Common Working File (CWF) shall apply the same rules to G0567 as applied to G0472.									
14041.9	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall modify the HUQA response to include HCPCS code G0567 in the HCV group**.**					X			X	
14041.10	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall create a one-time utility to capture all beneficiaries that have a Hepatitis C screening HCPCS G0567 from June 27, 2024, to the implementation date of this CR.								X	
14041.11	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall modify the HICR transaction HCHC to include the HCPC code G0567.								X	
14041.12	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall deny line-items on claims for	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	HCV screening HCPCS G0472, G0567 when submitted on TOBs other than 13X, 14X, or 85X Claim Adjustment Reason Codes (CARC) 170 – Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Codes (RARC) N95 This provider type/provider specialty may not bill this service. MSN 21.25 - This service was denied because Medicare only covers this service in certain settings. 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									
14041.13	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall deny line-items with HCPCS G0472 or G0567 and Place of Service codes (11, 19, 22, 49, 71, and		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	81) other than those listed with the following messages. CARC 171 – Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N428 - Not covered when performed in this place of service. MSN 21.25 - This service was denied because Medicare only covers this service in certain settings. Group Code CO assigning financial liability to the provider if a claim is received with a GZ modifier indicating no signed ABN is on file									
14041.14	NCD 210.13 Screening for Hepatitis C Virus (HCV) in adults Contractors shall implement system changes to prevent application of beneficiary coinsurance and deductibles to claim lines containing HCPCS G0472 effective on or after June 02, 2014 and G0567, effective for dates of service on	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	or after June 27, 2024.									
14041.15	Contractors shall not search claims but may adjust claims that are brought to their attention.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

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

VII. FUNDING

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