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In this issue

PBN Perspectives

Loper Bright ruling brings new challenges to health care rules: Experts

A Supreme Court decision has major repercussions for federal regulations, including the final rules on which health care providers rely. Experts say that even bedrock Medicare payment and coverage rules may now be vulnerable to challenge, but other rules with more limited impact are likely to be attacked first.

On June 28, the U.S. Supreme Court decision in Loper Bright Enterprises v. Raimondo effectively ended "Chevron deference" — that is, a precedent set in SCOTUS' 1984 Chevron USA v. National Resources Defense Council. That 1984 ruling in essence said that, where a federal law is ambiguous as to how it should be put into action by a federal agency, any "reasonable" regulation by such an agency should be presumed legitimate unless other factors leave it vulnerable to legal challenge. In Loper, the high court ruled 6-3 that this misread the Administrative Procedure Act, which governs agency implementation of congressional legislation.

Loper, in the words of SCOTUS Associate Justice Neil Gorsuch in his concurrence, "places a tombstone on Chevron no one can miss" and "returns judges to interpretative rules that have guided federal courts since the nation's founding" — that is, when a regulation is challenged in court, apart from judging on other merits, the courts rather than agencies will decide whether the law has been properly interpreted by the regulators.

Pre-Loper, courts typically ruled against regulations when they found them to violate the plain language of a statute, as in the Texas Medical Association's successful suits against federal rules based on the No Surprises Act (*PBN 2/20/23*). Now the

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courts are empowered to rule as well on ambiguities that they were previously compelled by precedent to leave to the agency's discretion.

The effect of Loper on health care and health care-adjacent regulation has already been felt — since the ruling, injunctions against the FTC's recent non-compete rule and HHS' anti-discrimination rule have been granted by judges who cited the end of Chevron deference as a factor in their decisions (*PBN 5/6/24*, *6/10/24*).

First: IVD, FCA, repro rights

Experts tell *Part B News* that you can expect more legal challenges to regulations, leading to more judges ruling on the legitimacy of rules.

Harry Nelson, founder and managing partner of Nelson Hardiman LLP, the largest health care and life sciences specialty law firm in Los Angeles, says, "number one, there will be significantly less deference to agency interpretation and so less discretion for federal agencies. Number two, there'll be much more of an opening for judicial activism [to get] judges to interpret in place of agencies."

Nelson names as a potential target the FDA's lab developed test final rule, published on May 6, which is meant to "tighten up limitations" on in vitro diagnostic products (IVD) after a long period of discretionary enforcement.

"FDA had created an opening where they basically said, if you're using a diagnostic test in combination with a physician service — for example, combining a telehealth platform with a genomic or any kind of diagnostic testing — you didn't necessarily have to go through FDA," Nelson says. But FDA's new rule said it was phasing out this deference, which has implications for many diagnostic companies, and if these companies go to court Nelson thinks they have a chance: "The whole scheme that [FDA] came up with is really all agency-developed without a clear legislative directive so it's likely to be very vulnerable right now."

Another potential target: False Claims Act and Anti-Kickback Statute cases against health care providers. Nelson says HHS and the U.S. Department of Justice have been "aggressive" in pursuing such cases "using a reckless-disregard standard — meaning you don't have to actually knowingly commit fraud, you just have to have reckless disregard for the accuracy of a claim you submitted [to violate the statute]."

Case judges, in Nelson's experience, "are actually more liberal in terms of giving more latitude to [defendants in these cases]. If you believe the government is overreaching on the use of the FCA in health care, you can expect the government to be more vulnerable to challenge on its positions." After Loper, you might see more judicial pushback in "gray area" prosecutions that invoke FCA and AKS in, for example, cases based on upcoding and unbundling.

Nelson also expects politically charged action in the area of reproductive rights — for example, HHS' interpretation of EMTALA with regard to abortion (*PBN 5/8/23*). Robert Bradner, a partner with Holland & Knight

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in Washington, D.C., agrees, and also sees potential action against the administration's rule requiring stronger HIPAA safeguards on protected health information (PHI) related to reproductive health care, and its selection of specific drugs for inclusion in the Medicare negotiated price program for Medicare drugs (*PBN 5/4/23*, *9/25/23*).

Reasons why they won't

But when it comes to the bread-and-butter issues of physician payments, such as is seen in the annual physician fee schedule rules, experts think litigants have less room to act.

On the one hand, Bradner says, "it is possible a judge could decide that 'reasonable' is an ambiguous term and insert themselves in those determinations." He also admits a possibility that some judges may decide CMS' "medically reasonable and necessary" coverage and non-coverage decisions, or FDA's "safety and effectiveness" determinations, "are ambiguous and the scientific standards being applied are subject to legal interpretation."

At the same time, "Medicare has pretty extensive definitions of reasonable cost and delegates the responsibility to HHS to establish reimbursement rates," Bradner says. "It also clearly empowers CMS to administer Medicare using contractors."

And the Loper decision itself acknowledges the role of regulators as agents of legislation, e.g., "when a particular statute delegates authority to an agency consistent with constitutional limits, courts must respect the delegation, while ensuring that the agency acts within it."

Thomas Barnard, a former Assistant United States Attorney and now a shareholder with Baker Donelson in Baltimore, says that, first, "potential challenges [to regulation] are only useful where (1) there is an ambiguous statute (2) to which an agency is applying its interpretation; and (3) a court has not already interpreted for the aspect to be challenged."

Barnard adds: "To challenge a particular agency action, you must go back to the 'enabling statute' that empowers the agency to act for that action and determine if the statute was explicit in either (1) how the agency should or should not act or (2) leaving discretion to the agency."

This may provide a bank against frivolous legal challenges; however, Barnard says, "vague or ambiguous terms designed to give an agency flexibility, but not specifically stated to give that discretion to an agency, could be a source of routine challenge."

Amanda Hill, founder of the Hill Health Law Group in Austin, Texas, nonetheless worries that Loper "will cause a back-up in the courts" — especially when combined with the impact of another recent SCOTUS decision, Corner Post v. Board of Governors of the Federal Reserve System. In that decision, rendered July 1, the justices ruled that the seven years' statute of limitations for challenges of federal rules did not start with the effective date of the rule, but with the claimed injury or harm caused by the rule — no matter when the rule was created.

"Our job as lawyers is try to think of creative arguments that we can use to attack a statute that hurts our client," Hill says. "So I think we are in for a lot of different lawsuits trying to argue in various ways that their people were harmed by regulatory interpretation of the law."

The consensus is that lawmakers will have to get much more prescriptive in their legislation as to how much discretion may be left to the agency.

"They can be explicit about what they are giving discretion to the agencies, and what they are not," Barnard says. "The Loper decision even mentions that the legislature can make it clear where they intend to give discretion."

"The natural outcome will be much more care in both legislative drafting and regulatory drafting," Nelson says. "Agencies have to be much more careful because they'll have less room [to interpret] and legislators have to be much more careful because they have less room to empower regulatory agencies." — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Supreme Court of the United States, *Loper Bright Enterprises et al. v. Raimondo*, June 28, 2024: www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf
- Supreme Court of the United States, *Corner Post, Inc. v. Board of Governors of the Federal Reserve System*, July 1: www.supremecourt.gov/opinions/23pdf/22-1008_1b82.pdf
- U.S. Chamber of Commerce v. FTC: www.hklaw.com/-/media/files/insights/publications/2024/07/070524alert_ryanllcvftcopinion.pdf?rev=d3a55e42bcad41548db1aa0cdeb7e270&hash=758FA8237717EEE83B11AF560B09E637
- Tennessee v. Becerra: www.documentcloud.org/documents/24789711-ruling-on-transgender-protections
- FDA, "Medical Devices; Laboratory Developed Tests," final rule, May 6, 2024: www.federalregister.gov/documents/2024/05/06/2024-08935/medical-devices-laboratory-developed-tests

Coding

CMS considers extra payment for some post-operative care work

Practitioners who provide post-operative care for patients without a formal transfer of care from the surgeon could receive a few extra dollars for their trouble if CMS finalizes a proposed add-on code (*PBN 7/29/24*). But CMS envisions a variety of limits for the new complexity of care code, including who can perform it, where it can be performed and a time limit for performing it.

Pay providers, track post-op care

CMS proposed the code (placeholder HCPCS code **GPOC1**) for two reasons. First, CMS seeks to recognize the additional work when a provider treats a patient during the post-surgical period without a formal transfer of care from the surgeon, in particular when the surgeon is of a different specialty or with a different practice.

"The practitioner providing the post-operative care may not be involved in creating the surgical plan, and may not have access to the operative notes to know how the surgery went or be abreast of any particular considerations related to the procedure that may factor in medical care decisions for the post-operative care," CMS explained in the proposed 2025 Medicare physician fee schedule.

In addition, CMS believes the code will help it track post-operative work performed without a formal transfer of care and "make meaningful progress toward 'right-sizing' the structure of the global packages," the agency explained in the proposed rule.

4 main conditions for coverage

CMS would pay approximately $8.74 for the complexity of care encounter, which would be limited to one reportable service during a 90-day post-surgical period. However, providers should note and comment on the following proposed conditions for payment:

1. The surgeon did not formally transfer the patient's post-operative care to the provider who performs the post-operative service.
2. The post-operative care provider and the surgeon are not of the same specialty or in the same practice. Providers in multispecialty practices can't assume that post-operative services for a new patient automatically qualify for the add-on code. They would need to make sure that the procedure was not performed by a co-worker from a different specialty.
3. The post-operative provider must list the surgical procedure, link the visit to post-operative care for the procedure and the visit must take place during the post-operative period of a major procedure.
4. The primary code is an office or other outpatient E/M code for a new or established patient (**99202-99215**). CMS does not intend to cover the code for visits in other settings such as the patient's home or a hospital.

Review the complete descriptor

Share the descriptor for the proposed code with team members who would be performing or reporting the service. This will help them understand what CMS intends, and give them an opportunity to submit a comment on this section of the proposed rule:

"Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 090-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:

- Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.
- Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).
- Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.
- Communicate with the practitioner who performed the procedure if any questions or concerns arise.

(List separately in addition to office/outpatient evaluation and management visit, new or established)."

(continued on p. 6)

Benchmark of the week

Losers outpace winners in 2025 PFS payment-adjustment chart

The grim conversion factor news in the proposed 2025 Medicare physician fee schedule only gets worse when you look at how it plays out in specific physician payments. According to the supplemental files published with the rule, only 173 out of 4,146 codes would see a positive adjustment from 2024 (*PBN 7/22/24*).

The average upward adjustments on those non-facility "winner" codes would be $4.28, while the average downward adjustment on the remaining 3,973 "loser" codes would be $14.22.

The big winner in the list is the cerebrovascular ultrasound exam code **93888** (Transcranial Doppler study of the intracranial arteries), followed by the OB/GYN exam component **59200** (Insertion of cervical dilator) and the ophthalmoscopy code **92240** (Indocyanine-green angiography, interp and report). The top three losers are imaging-related codes: **92134-26** (Scanning computerized ophthalmic diagnostic imaging, posterior segment, interp and report, unilateral or bilateral; retina; professional services only), **92133**-26 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, interp and report; optic nerve), and **92134** without the "professional services only" modifier.

You'll notice the winners' rates drop to single-digit increases in 11th place; the losers' rates, on the other hand, continue to fall by double digits through 63rd place.

Note: The "losers" chart does not include four colonoscopy codes — **G0105** (Colorectal cancer screen, high risk), **G0121** (... ; not high risk), **45378** (Colonoscopy, flexible, diagnostic) and **44388** (Colonoscopy through stoma, diagnostic) – that would lose less than 1% by themselves but when billed with modifier **53** (Discontinued procedure) would lose more than 50% of their 2024 payment rates under the rule.

And that's not all the bad news: All nine office E/M codes take hits between 1.83% and 2.80% in 2025, assuming no significant changes are made in the final rule. — *Roy Edroso* (*roy.edroso@decisionhealth.com*)

Codes with biggest percentage losses under the proposed PFS

Code	Modifier	Description	2024 non-facility pro fee	Proposed 2025 non-facility pro fee	Non-facility 2024-2025 percent change
92134	26	Cptr ophth dx img post segmt	$24.30	$17.15	-29.43%
92133	26	Cmptr ophth img optic nerve	$20.97	$15.85	-24.40%
92134		Cptr ophth dx img post segmt	$40.28	$31.39	-22.08%
92287	26	Ant sgm img ir flrscn angrph	$28.96	$22.65	-21.79%
93623	26	Stimulation pacing heart	$65.91	$51.77	-21.45%
G0168		Wound closure by adhesive	$121.83	$95.77	-21.39%
52005		Cystoscopy & ureter catheter	$302.92	$238.14	-21.38%
97814		Acupunct w/stimul addl 15m	$36.62	$28.80	-21.35%
52000		Cystoscopy	$239.34	$188.31	-21.32%
96922		Excimer lsr psriasis>500sqcm	$232.01	$182.81	-21.21%
92284		Dx dark adaptation exam i&r	$37.28	$29.44	-21.02%
79403		Hematopoietic nuclear tx	$208.71	$165.02	-20.94%
79403	26	Hematopoietic nuclear tx	$107.85	$85.74	-20.50%
52281		Cystoscopy and treatment	$325.88	$260.47	-20.07%
52332		Cystoscopy and treatment	$399.12	$319.68	-19.90%

Codes with biggest percentage gains under the proposed PFS

Code	Modifier	Description	2024 non-facility pro fee	Proposed 2025 non-facility pro fee	Non-facility 2024-2025 percent change
93888	26	Intracranial limited study	$24.30	$34.30	41.14%
59200		Insert cervical dilator	$105.19	$129.75	23.35%
92240		Icg angiography i&r uni/bi	$187.74	$230.70	22.88%
78111		Plasma volume multiple	$72.90	$89.30	22.50%
97810		Acupunct w/o stimul 15 min	$38.28	$44.65	16.64%
78111	26	Plasma volume multiple	$8.65	$10.03	15.89%
97813		Acupunct w/stimul 15 min	$45.27	$51.45	13.64%
65778		Cover eye w/membrane	$1,086.50	$1,226.62	12.90%
92242		Fluorescein&icg angiography	$280.61	$316.77	12.88%
95852		Range of motion measurements	$17.98	$20.06	11.60%
88355		M/phmtrc alys skeletal musc	$126.16	$138.48	9.77%
95851		Range of motion measurements	$21.64	$23.62	9.17%
97018		Paraffin bath therapy	$5.66	$6.15	8.64%
46930		Destroy internal hemorrhoids	$217.03	$234.26	7.94%
94450		Hypoxia response curve	$79.56	$85.74	7.78%

Source: Part B News *analysis of proposed 2025 Medicare physician fee schedule supplementary files*

(continued from p. 4)

CMS has requested comment on the typical time and work physicians and practitioners spend over and above a separately billed E/M visit when they provide post-operative care to a patient under the conditions and for the work the agency described in the proposed rule.

Comments for the proposed rule are due Monday, Sept. 9, 2024. The quickest way to submit a comment is through the *regulations.gov* website, where you can also download a copy of the proposed rule by searching for CMS-1807-P. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

Practice management

Don't let patient disputes escalate; plan to protect yourself

Minor patient disputes that do not rise to the level of malpractice or negligence can still be troublesome for a practice, especially if poor handling lets them get out of hand. Have an action plan in place to address them when they arise to avoid seeming brusque, overpromising or encouraging a more negative reaction.

Sometimes patients have serious issues with medical treatment — or serious non-medical issues, such as the sexual assault on a patient in a California chiropractic office earlier this year — that require an immediate escalation to lawyers and/or law enforcement (*PBN 4/8/24*). But sometimes patients have issues that can be resolved more easily if the practice is able to de-escalate the situation.

A dissatisfied patient can be a public relations disaster for your practice. Recall the patient who fell asleep in an Alabama practice in 2022 and woke up to find the staff had left for the day; she went to the press about it and her story was widely covered throughout the state (*see resources, below*).

While there's no guarantee that an action plan will dissuade an aggrieved patient from publicizing the incident or even taking you to court, experts say that keeping such a plan is a best practice and has been known to help.

Larger health care practices and health systems "typically have a 'patient advocate' department that responds to complaints," says Kimberly J. Ruppel, member and health care litigation task force chair at Dickinson Wright in Troy, Mich. "Ideally, that department is staffed by people who follow a customer service approach and try to de-escalate issues."

While you may not have that kind of bandwidth, you may have someone on staff, at least, with the people skills you may need to navigate a tough situation, and you can train everybody in appropriate responses.

What gets escalated?

First, you should be clear about what staff and management can't handle alone and requires a call to legal counsel. For example, Amanda Hill, founder of the Hill Health Law Group in Austin, Texas, says even if management has the situation in hand, you should involve legal in any settlement "that is rather large and requires a release."

Hill says, "if you're a plastic surgeon and you're refunding a $5,000 surgery because the patient is arguing you didn't do it right and there is dimpling or sagging skin, you want a full release of claims, confidentiality, and a non-disparagement provision that they won't post or write or talk badly about you in any forum, online or otherwise."

Striking 'a delicate balance'

For smaller grievances, like an umbrella that goes missing in a waiting room, the first step is conciliation, usually with a conditional admission of fault — that is, one that doesn't unnecessarily expose you to legal liability.

"Acknowledging fault can be a delicate balance," says Connie Kurczewski, founder of Elevated Practice Consulting in Greenwich, Conn. "It's essential to express empathy and concern without necessarily admitting legal liability. Phrases like 'we are deeply sorry for the inconvenience and are investigating how this happened' can show compassion while protecting the practice. Staff should be trained on what to say and, equally important, what not to say."

On the latter note, Kurczewski says it would be counterproductive to say, for example, "This should never have happened" or "We clearly messed up here."

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

"This implies a serious mistake was made, which can be seen as admitting fault," Kurczewski says. "Directly admitting a mistake can be problematic in a legal context."

Other responses to avoid include "I know this was our fault" and "We've had similar problems before."

Gently out the door

Sometimes the problem can't be fixed on the spot. Try to give the patient what they want, but if you've run out of immediate options and the patient remains dissatisfied, have some language ready to use that smooths their way to the exit until such time as you can come back with a new solution.

Kurczewski has some scripts for this, e.g.: "We understand your concerns and are truly sorry for any distress this situation has caused. We are committed to thoroughly investigating this matter and ensuring it does not happen again. At this point, we need to conclude our discussion to complete our review. We will keep you informed of any findings and corrective actions taken."

The goal "is to respond in a way that conveys empathy and a commitment to resolving the issue while also setting clear boundaries to prevent the conversation from becoming counterproductive," Kurczewski says.

Of course, all that work must lead to some sort of resolution, so "follow-up with the patient is also critical," Kurczewski says. "A call or a letter from management to check on their well-being and offer any necessary support can go a long way in repairing the relationship."

5 more tips

- **Keep records.** Make a proper incident report including time, issue, the persons involved, and resolution/next steps. Such recordkeeping "is vital for internal records and any potential legal proceedings," Kurczewski says. Be aware that the patient's identity makes this document confidential under HIPAA, unless a genuinely compelling legal requirement allows you to reveal it (*PBN 3/4/24*).
- **Have the doctor talk.** Some providers are bad at the "soft skills" of patient contact, but if yours are not, try to get them to take over from staff and talk to the patient. "Too often, doctors want their staff to handle 'the hard stuff' when it can be cleared up with a phone call," Hill says. "The soothing voice of their doctor saying, 'I care about you and want to make this right,' goes a long way in a patient's eyes."
- **Eat the bill.** Hill tells her physician clients that "if there's a huge issue with a patient over an $80 bill, and there is a way you can just waive the office visit charge, do it. If it's less than a few hundred dollars, it's not worth your time to dig deep and fight, even if you feel you're in the right."
- **Conduct audits.** Compliance officers will tell you any program that addresses legal or regulatory perils in the practice should be reviewed at regular intervals to make sure it's still effective. That goes for your patient complaint protocol as well.

  Richard F. Cahill, vice president and associate general counsel of the Doctor's Company in Napa, Calif., recommends "periodic audits of policies and procedures [to] assist in promoting consistent application of office protocols, demonstrating due diligence at critical steps in the process as may be useful in defending against a subsequent lawsuit, and helping to ensure ongoing efficient business functions even in the event of an unintended problem." Consult with legal counsel on this, and also with your insurers, who may have useful advice or, more to the point, specific requirements for handling these scenarios when they arise.
- **Make sure you're insured.** Cahill reminds you to keep your general premises liability insurance up to date.

— Roy Edroso (roy.edroso@decisionhealth.com) ■

RESOURCE

- AL.com, "Alabama woman falls asleep in American Family Care, wakes up alone in empty doctor's office," Nov. 13, 2022: www.al.com/news/2022/11/alabama-woman-falls-asleep-in-american-family-care-wakes-up-alone-in-empty-doctors-office.html

Coding

The next ICD-10-CM code set is expansion packed

Alert your team to new diagnosis codes that will require more detail at the documentation and coding level. The FY2025 ICD-10-CM code set deletes a variety of more general diagnosis codes and replaces them with dozens of specific codes. For example, four new codes will replace **E66.8** (Other obesity):

- **E66.811** (Obesity, class 1).
- **E66.812** (Obesity, class 2).
- **E66.813** (Obesity, class 3).
- **E66.89** (Other obesity not elsewhere classified).

Here are five more examples of codes that will expand when the new code set goes into effect Oct. 1, 2024:

1. **Chapter 2: Neoplasms (C00-D49)** — Providers will need to specify whether a neoplasm is in remission for 13 neoplasm codes, such as **C86.00** (Extranodal NK/T-cell lymphoma, nasal type not having achieved remission) and **C86.01** (Extranodal NK/T-cell lymphoma, nasal type, in remission) in place of deleted code **C86.0** (Extranodal NK/T-cell lymphoma, nasal type).
2. **Chapter 5: Mental, behavioral and neurodevelopmental disorders (F01-F99)** — Four eating disorder codes for conditions such as anorexia nervosa, restricting type and bulimia nervous will each be replaced by six codes that align with the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). For example, the update deletes **F50.01** (Anorexia nervosa, restricting type) and replaces it with **F50.010** (Anorexia nervosa, restricting type, mild), **F50.011** (… ; moderate), **F50.012** (... ; severe), **F50.013** (... ; extreme), **F50.014** (... ; in remission) and **F50.019** (... ; unspecified).
3. **Chapter 11: Diseases of the digestive system (K00-K95)** — The update will replace the three codes for anal, rectal and anorectal fistula codes with a total of 24 codes based on whether the fistula is simple or complex and initial, persistent, recurrent or unspecified.
4. **Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)** — One code takes the prize for the largest expansion in the next ICD-10-CM code set. **M65.9** (Synovitis and tenosynovitis, unspecified) will be replaced by 24 codes based on specific anatomic sites.
5. **Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)** — Four codes will replace code **Z86.010** (Personal history of colonic polyps). The new codes will be based on the type of polyp, when known.

For a complete list of the FY2025 ICD-10-CM codes, download the Excel file under the Tools section of the *Part B News* website. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- 2025 Code Descriptions in Tabular Order (zip file): *www.cms.gov/files/zip/2025-code-descriptions-tabular-order.zip*
- ICD-10 Coordination and Maintenance Committee Meeting, March 7-8, 2023, Diagnosis Agenda: *www.cdc.gov/nchs/data/icd/topic-packet-march-7-8-final-3-6-23.pdf*
- ICD-10 Coordination and Maintenance Committee Meeting, September 12-13, 2023, Diagnosis Agenda: *www.cdc.gov/nchs/data/icd/Topic-packet-September-2023-Final.pdf*

Coding

Train your team with the complete ICD-10-CM code set

Prepare members of your treatment and coding teams for changes to the diagnosis code set that will go into effect Oct. 1, 2024 (*see story, above*). Download and share the Excel file that contains five spreadsheets:

1. A complete list of codes that were added, revised or deleted, that CMS released on July 9.
2. A color-coded list that makes it easier to compare the changes.
3. Added codes.
4. Revised codes.
5. Deleted codes.

Watch upcoming issues of *Part B News* for more information on the latest ICD-10-CM update. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*)