Cotiviti Approved Issues List as of April 04, 2022

All physician/NPP specialties	32
Ambulance Providers	34
Ambulatory Surgery Center (ASC), Outpatient Hospital	38
Inpatient Hospital	40
Inpatient Hospital, Inpatient Psychiatric Facility	46
Inpatient, Outpatient, ASC, Physician	48
IP, OP, SNF, OP Clinics, ORF, CORF	50
OPH, OP Non-Hospital, SNF, ORF, CORF, Physician	52
Outpatient Hospital	54
Outpatient Hospital (OPH), Physician/Non-physician	56
Outpatient Hospital, ASC	57
Outpatient Hospital, ASC, Physician/Non-Physician	59
Outpatient Hospital, Inpatient Hospital	61
Outpatient Hospital, Physician	63
Outpatient Hospital, Physician/NPP, Lab/Ambulance	66
Outpatient Hospital; Physician	68
Physician, Outpatient Hospital, Professional Services	70
Physician, Professional Services	72
Physician, Professional Services/Outpatient Hospital	78
Physician/Non-physician Practitioner	80
Physician/Non-physician Practitioner (NPP)	82
Physician/NPP	84
Professional Services (Physician/Non-Physician)	86
Radiologists/Part B providers doing radiology service	110
SNF	112

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Coding changes may result in a partial overpayment or under payment. Non-receipt of records will result in a full overpayment. Clinical Validation is not permitted.	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review; 7) CMS QIO Manual Section 4130; 8) ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 9) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 10) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017	Approved
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Coding changes may result in a partial overpayment or under payment. Non-receipt of records will result in a full overpayment. Clinical Validation is not permitted.	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review; 7) CMS QIO Manual Section 4130; 8) ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 9) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 10) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0002 - Cataract Removal: Medical Necessity and Documentation Requirements	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states; excluding WPS	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10- Anesthesia and Pain Management, §10.1- Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery; Effective 10/03/2003; Revised 02/15/2019; 6) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.10- Phaco-Emulsification Procedure - Cataract Extraction Effective 10/03/03; Revised 02/15/2019; 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.12- Intraocular Lenses (IOLs), Effective 10/03/2003; Revised 02/15/2019; 8) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9) CGS LCD L33954- Cataract Extraction; Effective 10/01/2015; Revised 12/24/20; 10) NGS LCD L33558- Cataract Extraction; Effective 10/1/2015; Revised 09/19/2019; 11) Noridian LCD L34203- Cataract Surgery in Adults; Effective 10/01/2015; Revised 10/01/19; 12) Noridian LCD L37027- Cataract Surgery in Adults; Effective 10/10/2017; Revised 10/01/2019; 13) Palmetto LCD L34413- Cataract Surgery; Effective 10/01/2015; Revised 10/10/19; 14) Palmetto LCA A53047- Complex Cataract Surgery: Appropriate Use and Documentation; Effective 10/01/2015; Revised 01/01/2020; 15) Novitas LCD L35091- Cataract Extraction (including Complex Cataract Surgery), Effective 10/01/2015; Revised 07/11/21; 16) First Coast LCD L33808- Cataract Extraction; Effective 10/01/2015; Retired 10/29/2019; 17) Cahaba LCD L34287- Cataract Extraction; Effective 10/01/2015, PART B ONLY; Retired 02/25/2018; 18) NGS LCA A56544- Cataract Extraction; Effective 08/01/2019; Revised 01/01/2020; 19) Noridan LCA A57195 Billing and Coding: Cataract Surgery in Adults; Effective 10/01/2019; Revised 01/01/2020	Complex	2/12/2017	Approved
Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0002 - Cataract Removal: Medical Necessity and Documentation Requirements	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10- Anesthesia and Pain Management, §10.1- Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery; Effective 10/03/2003; Revised 02/15/2019; 6) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.10- Phaco-Emulsification Procedure - Cataract Extraction Effective 10/03/03; Revised 02/15/2019; 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §10 Anesthesia and Pain Management, §80- Eye, §80.12- Intraocular Lenses (IOLs), Effective 10/03/2003; Revised 02/15/2019; 8) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9) CGS LCD L33954- Cataract Extraction; Effective 10/01/2015; Revised 12/24/20; 10) NGS LCD L33558- Cataract Extraction; Effective 10/1/2015; Revised 09/19/2019; 11) Noridian LCD L34203- Cataract Surgery in Adults; Effective 10/01/2015; Revised 10/01/19; 12) Noridian LCD L37027- Cataract Surgery in Adults; Effective 10/10/2017; Revised 10/01/2019; 13) Palmetto LCD L34413- Cataract Surgery; Effective 10/01/2015; Revised 10/10/19; 14) Palmetto LCA A53047- Complex Cataract Surgery: Appropriate Use and Documentation; Effective 10/01/2015; Revised 01/01/2020; 15) Novitas LCD L35091- Cataract Extraction (including Complex Cataract Surgery), Effective 10/01/2015; Revised 07/11/21; 16) First Coast LCD L33808- Cataract Extraction; Effective 10/01/2015; Retired 10/29/2019; 17) Cahaba LCD L34287- Cataract Extraction; Effective 10/01/2015, PART B ONLY; Retired 02/25/2018; 18) NGS LCA A56544- Cataract Extraction; Effective 08/01/2019; Revised 01/01/2020; 19) Noridan LCA A57195 Billing and Coding: Cataract Surgery in Adults; Effective 10/01/2019; Revised 01/01/2020	Complex	2/12/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient, Outpatient, ASC, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; 6) Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; 7) First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Revised 08/06/2019; Retired 8/13/2020; 8) First Coast Service Options, Inc., LCA A56508 - Billing and Coding: Sacral Neuromodulation, Effective 01/08/2019, Retired 08/13/2020; 9) Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 04/18/2019; Retired 8/13/2020; 10) Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 11) Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 12) CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; Revised 03/04/2021; 13) CPT Assistant, December 2012, Volume 22, Issue 12, page 14- Surgery: Nervous System, Placement Permanent Neurostimulator Electrode Array with Implant of Pulse Generator	Complex	1/23/2017	Approved
Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient, Outpatient, ASC, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; 6) Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; 7) First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Revised 08/06/2019; Retired 8/13/2020; 8) First Coast Service Options, Inc., LCA A56508 - Billing and Coding: Sacral Neuromodulation, Effective 01/08/2019, Retired 08/13/2020; 9) Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 04/18/2019; Retired 8/13/2020; 10) Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 11) Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 12) CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; Revised 03/04/2021; 13) CPT Assistant, December 2012, Volume 22, Issue 12, page 14- Surgery: Nervous System, Placement Permanent Neurostimulator Electrode Array with Implant of Pulse Generator	Complex	1/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0004 - Skilled Nursing Facility: Medical Necessity and Documentation Requirements	SNF	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations 405.986- Good Cause for Reopening; 5) 42 Code of Federal Regulations 409.30-409.36- Basic requirement; Level of care requirement; Criteria for skilled services and the need for skilled services; Examples for skilled nursing and rehabilitation services; Criteria for “daily basis”; Criteria for “practical matter”; Effect of discharge from posthospital SNF care.; 6) 42 Code of Federal Regulations 424.20- Requirements for posthospital SNF care; 7) 42 Code of Federal Regulations 483.30 – Physician Services; 8) 42 Code of Federal Regulations 483.20- Resident assessment; 9) 42 Code of Federal Regulations 411.15(k)(1)- Particular services excluded from coverage; 10) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11) Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40.4- Timing of Recertifications for Extended Care Services, §40.5- Delayed Certifications and Recertifications for Extended Care Services; 12) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services; §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills; §6.1.3- Bill Review Requirements; §6.1.4- Medical Review Process; §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 13) Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 14) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.1.3- Certification and Recertification of Need for Treatment and Therapy Plans of Care	Complex	6/13/2017	Approved
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0004 - Skilled Nursing Facility: Medical Necessity and Documentation Requirements	SNF	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations 405.986- Good Cause for Reopening; 5) 42 Code of Federal Regulations 409.30-409.36- Basic requirement; Level of care requirement; Criteria for skilled services and the need for skilled services; Examples for skilled nursing and rehabilitation services; Criteria for “daily basis”; Criteria for “practical matter”; Effect of discharge from posthospital SNF care.; 6) 42 Code of Federal Regulations 424.20- Requirements for posthospital SNF care; 7) 42 Code of Federal Regulations 483.30 – Physician Services; 8) 42 Code of Federal Regulations 483.20- Resident assessment; 9) 42 Code of Federal Regulations 411.15(k)(1)- Particular services excluded from coverage; 10) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11) Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40.4- Timing of Recertifications for Extended Care Services, §40.5- Delayed Certifications and Recertifications for Extended Care Services; 12) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services; §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills; §6.1.3- Bill Review Requirements; §6.1.4- Medical Review Process; §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 13) Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 14) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.1.3- Certification and Recertification of Need for Treatment and Therapy Plans of Care	Complex	6/13/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary and may result in an overpayment.	0008 - Bariatric Surgery: Medical Necessity and Documentation Requirements	Outpatient Hospital, Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; 8) First Coast LCD L33411- Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/01/2019; 9) Palmetto GBA LCD L34576- Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 10/1/2015; Revised 12/10/2020; 10) Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/01/2015; Revised 05/13/2021; 11) NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/01/2015; Revision 10/01/2020; 12) Noridian LCA A53026- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2021; 13) Noridian LCA A53028- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2020, Revision Ending 09/30/2021; 14) Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2020; 15) WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/01/2016; Revised: 10/01/2020; 16) Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/01/2020; Revision ending 09/30/2021; 17) First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; Revised 10/01/2020; 18) First Coast LCA A55930- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 3/15/2018; 19) First Coast LCA A56182- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 11/06/2018	Complex	1/23/2017	Approved
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary and may result in an overpayment.	0008 - Bariatric Surgery: Medical Necessity and Documentation Requirements	Outpatient Hospital, Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; 8) First Coast LCD L33411- Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/01/2019; 9) Palmetto GBA LCD L34576- Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 10/1/2015; Revised 12/10/2020; 10) Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/01/2015; Revised 05/13/2021; 11) NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/01/2015; Revision 10/01/2020; 12) Noridian LCA A53026- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2021; 13) Noridian LCA A53028- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2020, Revision Ending 09/30/2021; 14) Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2020; 15) WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/01/2016; Revised: 10/01/2020; 16) Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/01/2020; Revision ending 09/30/2021; 17) First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; Revised 10/01/2020; 18) First Coast LCA A55930- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 3/15/2018; 19) First Coast LCA A56182- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 11/06/2018	Complex	1/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cardiac PET Scans meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0010 - Cardiac Positron Emission Tomography Scans: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - Florida, PR and VI ONLY	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 (e)(1)(B)- Advanced diagnostic imaging services defined; 4) Social Security Act (SSA), Title XVIII – Health Insurance for the Aged and Disabled, Section 1862 (a)(7) – Excludes routine physical examinations; 5) Social Security Act (SSA), Title XVIII – Definitions of Services, Institutions, Section 1861(s)(3) – Medical and Other Health Services; 6) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7) 42 CFR §405.986- Good Cause for Reopening; 8) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9) Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, Section 220.6.1- PET for Perfusion of the Heart; 10) Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, §220.6.8- FDG PET for Myocardial Viability; 11) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §50- Nuclear Medicine; 12) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60- Positron Emission Tomography (PET) Scans- General Information; 13) Medicare Claims Processing Manual, Chapter 13 – Radiology Services and Other Diagnostic Procedures, § 60.4 – PET Scans for imaging of the Perfusion of the Heart Using Rubidium 82 (RB 82); 14) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.9- Coverage of PET Scans for Myocardial Viability; 15) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.11- Coverage of PET Scans for Perfusion of the Heart Using Ammonia N-13; 16) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provisions in LCDs; 17) First Coast LCD L36209- Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET, Effective 10/01/2015; Retired 03/15/2020; 18) First Coast LCD L38396 - Cardiology – Non-emergent Outpatient Stress Testing, Effective 03/15/2020; Revised 4/25/2021; 19) First Coast LCA A56952 – Billing and Coding: Cardiology – Non-emergent Outpatient Stress Testing, Effective 03/15/2020, Revised	Complex	1/24/2017	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Inpatient	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; Issued: 12-02-05, Effective: 01-01-06, Implementation: 01-03-06; 7) CPT Manual 2013-Present	Automated	1/29/2017	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Inpatient	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; Issued: 12-02-05, Effective: 01-01-06, Implementation: 01-03-06; 7) CPT Manual 2013-Present	Automated	1/29/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay. Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Inpatient Psychiatric Stay Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4.1- Source of Admission for IPF PPS Claims for Payment of ED Adjustment; 8) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.10.1- General Rules	Automated	2/27/2017	Approved
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay. Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Inpatient Psychiatric Stay Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4.1- Source of Admission for IPF PPS Claims for Payment of ED Adjustment; 8) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.10.1- General Rules	Automated	2/27/2017	Approved
Reviewers shall complete a complex medical review to determine if endomyocardial biopsy and right heart catheterization were performed as two distinct services. The review shall identify claims where modifier 59 or XU have been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together. Billed services that are not supported by medical record documentation will result in an overpayment.	0027 - Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 23 (Fee Scheduled Administration and Coding Requirements), §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifier "-59"; 7) NCCI Manuals, Chapter 1- General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 8) NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare; 9) CPT Manual	Complex	4/3/2017	Approved
Reviewers shall complete a complex medical review to determine if endomyocardial biopsy and right heart catheterization were performed as two distinct services. The review shall identify claims where modifier 59 or XU have been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together. Billed services that are not supported by medical record documentation will result in an overpayment.	0027 - Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 23 (Fee Scheduled Administration and Coding Requirements), §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifier "-59"; 7) NCCI Manuals, Chapter 1- General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 8) NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare; 9) CPT Manual	Complex	4/3/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied. HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) is a "one time" allowed Medicare benefit per beneficiary	0028 - Annual Wellness Visits: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations (CFR) §410.15-Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 7) 42 Code of Federal Regulations (CFR) § 411.15- Particular services excluded from coverage (a) -Routine physical checkups such as Particular services excluded from coverage (1)- Examinations performed for a purpose; 8) 42 Code of Federal Regulations (CFR)§411.15- Particular services excluded from coverage (k)- Any services that are not reasonable and necessary (15)- In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in § 410.64 of this chapter.; 9) Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 10) Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 12 (Physicians/Nonphysician Practitioners), §30.6.1.1- Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV); 11) Internet Only Manual, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV] (Effective 1/27/2014); 12) Medicare Claims Processing Manual, Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit	Automated	4/26/2017	Approved
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied. HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) is a "one time" allowed Medicare benefit per beneficiary	0028 - Annual Wellness Visits: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations (CFR) §410.15-Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 7) 42 Code of Federal Regulations (CFR) § 411.15- Particular services excluded from coverage (a) -Routine physical checkups such as Particular services excluded from coverage (1)- Examinations performed for a purpose; 8) 42 Code of Federal Regulations (CFR)§411.15- Particular services excluded from coverage (k)- Any services that are not reasonable and necessary (15)- In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in § 410.64 of this chapter.; 9) Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 10) Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 12 (Physicians/Nonphysician Practitioners), §30.6.1.1- Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV); 11) Internet Only Manual, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV] (Effective 1/27/2014); 12) Medicare Claims Processing Manual, Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit	Automated	4/26/2017	Approved
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are “per diem” services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Hospital Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations §424.5(a)(6)- Basic conditions; Sufficient information; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), Effective: 01-01-11; 8) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231 - 99239), Effective: 04-01-08; 9) American Medical Association (AMA), Current Procedure Terminology 2007 to Present	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are “per diem” services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Hospital Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations §424.5(a)(6)- Basic conditions; Sufficient information; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), Effective: 01-01-11; 8) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231 - 99239), Effective: 04-01-08; 9) American Medical Association (AMA), Current Procedure Terminology 2007 to Present	Automated	3/23/2017	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply. Hospital Care CPT codes 99221-99223, 99231-99233 and 99238-99239 will result in an overpayment and payment will be recovered.	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.D- Visits to Patients in Swing Beds	Automated	3/23/2017	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply. Hospital Care CPT codes 99221-99223, 99231-99233 and 99238-99239 will result in an overpayment and payment will be recovered.	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.D- Visits to Patients in Swing Beds	Automated	3/23/2017	Approved
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests and §3.5.1 (Re-opening Claims) and §3.6 (Determinations Made During Review); 7) Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioners, § 30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201-99215), (A) Definition of New Patient for Selection of E/M Visit Code.	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests and §3.5.1 (Re-opening Claims) and §3.6 (Determinations Made During Review); 7) Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioners, § 30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201-99215), (A) Definition of New Patient for Selection of E/M Visit Code.	Automated	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting. Services billed incorrectly will result in an overpayment and will be recouped.	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6- - Evaluation and Management Service Codes - General (Codes 99201 - 99499), §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), §30.6.10- Consultation Services; 7) CPT Coding Manual	Automated	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting. Services billed incorrectly will result in an overpayment and will be recouped.	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6- - Evaluation and Management Service Codes - General (Codes 99201 - 99499), §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), §30.6.10- Consultation Services; 7) CPT Coding Manual	Automated	3/23/2017	Approved
The subsequently billed new patient visit will be denied if another E/M procedure has been billed within the past 3 years.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a) (1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 8) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.7.A-Definition of New Patient for Selection of E/M Visit Code; 9) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 10) AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The subsequently billed new patient visit will be denied if another E/M procedure has been billed within the past 3 years.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a) (1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 8) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.7.A-Definition of New Patient for Selection of E/M Visit Code; 9) Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 10) AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017	Approved
Claims for CPT code 67228 (Treatment of extensive or progressive retinopathy), billed more frequently than once per eye within the global surgery period will be denied.	0047 - Panretinal (Scatter) Laser Photocoagulation: Excessive Frequency	Outpatient Hospital (OPH), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - NGS states only: IL, MN, WI	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1833(e) - Payment of Benefits; 3) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 4) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions), §3.5.1- Reopening Claims and §3.6- Determinations Made During Review; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions), §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8) CGS Administrators, Local Coverage Determination (LCD) L34064- Panretinal (Scatter) Laser Photocoagulation; Effective 10/01/2015; Revised 3/4/2021; 9) NGS, Local Coverage Determination (LCD) L33628- Panretinal (Scatter) Laser Photocoagulation; Effective 10/01/2015; Revised 9/19/2019; 10) CGS Administrators, Local Coverage Article A56594- Billing and Coding: Panretinal (Scatter) Laser Photocoagulation; Effective 10/03/2019; Revised 3/4/2021; 11) NGS, Local Coverage Article A56550- Billing and Coding: Panretinal (Scatter) Laser Photocoagulation; Effective 8/1/2019; Revised 9/19/2019	Automated	4/26/2017	Approved
Algorithm identifies all paid Ambulance Claims billed with any HCPCS codes listed in Appendix D with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNFs' Medicare Part A payments and is subject to consolidated billing. Therefore, Medicare Part B payments that suppliers receive for the ambulance transportation are overpayments.	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual; Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, §20.3.1- Ambulance Services; 7) Medicare Claims Processing Manual, Chapter 15- Ambulance, § 30.2.2- SNF Billing; 8) American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; 9) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10.3.3- Separately Payable Ambulance Transport Under Part B Versus Patient Transportation That is Covered Under a Packaged Institutional Service	Automated	8/8/2017	Approved
Algorithm identifies all paid Ambulance Claims billed with any HCPCS codes listed in Appendix D with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNFs' Medicare Part A payments and is subject to consolidated billing. Therefore, Medicare Part B payments that suppliers receive for the ambulance transportation are overpayments.	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual; Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, §20.3.1- Ambulance Services; 7) Medicare Claims Processing Manual, Chapter 15- Ambulance, § 30.2.2- SNF Billing; 8) American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; 9) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10.3.3- Separately Payable Ambulance Transport Under Part B Versus Patient Transportation That is Covered Under a Packaged Institutional Service	Automated	8/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or Denied Primary Code	Professional Services (Physician/Non-Physician Practitioners); Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §70 Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40.8- Claims for Co-Surgeons and Team Surgeons; §40.9- Procedures Billed With Two or More Surgical Modifiers; 9) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 10) Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	1/22/2021	Approved
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or Denied Primary Code	Professional Services (Physician/Non-Physician Practitioners); Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §70 Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40.8- Claims for Co-Surgeons and Team Surgeons; §40.9- Procedures Billed With Two or More Surgical Modifiers; 9) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 10) Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	1/22/2021	Approved
Claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider, will be denied. Denied claims (or claim lines) will result in an overpayment and payment will be recovered.	0051 - Global versus Technical Component/Professional Component Reimbursements: Unbundling	Professional Services (Physician/Non-Physician Practitioner), Lab/Ambulance	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 6) Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 7) Medicare Claims Processing Manual, Chapter 13 (Radiology Services and Other Diagnostic Procedures), §20.1 (Professional Component [PC]), 20.2 (Technical Component [TC]), and 20.2.3 (Services Furnished in Leased Departments); 8) Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 9) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 10) Facility Outpatient Hospital Services and Practitioner Services MUE Tables; 11) Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider, will be denied. Denied claims (or claim lines) will result in an overpayment and payment will be recovered.	0051 - Global versus Technical Component/Professional Component Reimbursements: Unbundling	Professional Services (Physician/Non-Physician Practitioner), Lab/Ambulance	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 6) Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 7) Medicare Claims Processing Manual, Chapter 13 (Radiology Services and Other Diagnostic Procedures), §20.1 (Professional Component [PC]), 20.2 (Technical Component [TC]), and 20.2.3 (Services Furnished in Leased Departments); 8) Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 9) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 10) Facility Outpatient Hospital Services and Practitioner Services MUE Tables; 11) Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files	Automated	4/26/2017	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility. The edits will capture improper payment of ambulance services during an inpatient hospital stay.	0054 - Ambulance Billed during Inpatient: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 7) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4 CWF Editing of Ambulance Claims for Inpatients	Automated	6/20/2017	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility. The edits will capture improper payment of ambulance services during an inpatient hospital stay.	0054 - Ambulance Billed during Inpatient: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 7) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4 CWF Editing of Ambulance Claims for Inpatients	Automated	6/20/2017	Approved
Claims with CPT inpatient hospital care evaluation and management (E/M) codes billed for services rendered to a patient residing in a skilled nursing facility (SNF), with no inpatient hospital facility claim for the same date of service, will be adjusted to equivalent CPT SNF E/M codes.	0056 - Evaluation and Management Services in Skilled Nursing Facilities: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7) American Medical Association (AMA) Current Terminology Manual (CPT), Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims with CPT inpatient hospital care evaluation and management (E/M) codes billed for services rendered to a patient residing in a skilled nursing facility (SNF), with no inpatient hospital facility claim for the same date of service, will be adjusted to equivalent CPT SNF E/M codes.	0056 - Evaluation and Management Services in Skilled Nursing Facilities: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7) American Medical Association (AMA) Current Terminology Manual (CPT), Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved
Shoulder arthroscopy procedures include a limited debridement (CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter. Services billed incorrectly will result in an overpayment and will be recouped.	0057 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 7) National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014; Revised January 1, 2020	Complex	9/8/2017	Approved
Shoulder arthroscopy procedures include a limited debridement (CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter. Services billed incorrectly will result in an overpayment and will be recouped.	0057 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 7) National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014; Revised January 1, 2020	Complex	9/8/2017	Approved
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider should enter a 1 in the units billed column per date of service.	0060 - Untimed Therapy: Excessive Units	OPH, OP Non-Hospital, SNF, ORF, CORF, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual: Chapter 15- Covered Medical and Other Health Services, §220- Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services Under Medical Insurance; §230- Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 7) Medicare Claims Processing Manual, Chapter 5- Part B Outpatient Rehabilitation and CORF/OPT Services, §10.3.2- Exceptions Process; §10.6- Functional Reporting; §20.2- Reporting of Service Units with HCPCS; 8) American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider should enter a 1 in the units billed column per date of service.	0060 - Untimed Therapy: Excessive Units	OPH, OP Non-Hospital, SNF, ORF, CORF, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual: Chapter 15- Covered Medical and Other Health Services, §220- Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services Under Medical Insurance; §230- Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 7) Medicare Claims Processing Manual, Chapter 5- Part B Outpatient Rehabilitation and CORF/OPT Services, §10.3.2- Exceptions Process; §10.6- Functional Reporting; §20.2- Reporting of Service Units with HCPCS; 8) American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017	Approved
The Nursing Facility Services codes represent a “per day” service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service. Relevant CPT codes billed more than once per day will result in an overpayment.	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 3) 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, § 30.6.13 Nursing Facility Services, (B) Visits to Comply with Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF; 7) Medicare Program Integrity Manual, Chapter 3, §3.2.3.8 No Response or Insufficient Response to Additional Documentation Requests; 8) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 9) Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), §3.5.1 Re-opening Claims, §3.6 Determinations Made During Review; 10) American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 11) Novitas Local Coverage Determination: Evaluation and Management Services Provided in a Nursing Facility (L35068), Effective for services performed on or after 10/01/15, Revised for services performed on or after 11/21/2019; 12) Novitas Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Effective 07/25/19, Revised 11/21/2019; 13) First Coast Local Coverage Determination: Evaluation and Management Services in a Nursing Facility (L36230), Effective for services performed on or after 11/15/15, Revised for services performed on or after 01/08/19; 14) First Coast Local Coverage Article: Billing and Coding: Evaluation and Management Services in a Nursing Facility (A57724), Effective 10/03/18	Automated	9/8/2017	Approved
The Nursing Facility Services codes represent a “per day” service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service. Relevant CPT codes billed more than once per day will result in an overpayment.	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 3) 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, § 30.6.13 Nursing Facility Services, (B) Visits to Comply with Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF; 7) Medicare Program Integrity Manual, Chapter 3, §3.2.3.8 No Response or Insufficient Response to Additional Documentation Requests; 8) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 9) Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), §3.5.1 Re-opening Claims, §3.6 Determinations Made During Review; 10) American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 11) Novitas Local Coverage Determination: Evaluation and Management Services Provided in a Nursing Facility (L35068), Effective for services performed on or after 10/01/15, Revised for services performed on or after 11/21/2019; 12) Novitas Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Effective 07/25/19, Revised 11/21/2019; 13) First Coast Local Coverage Determination: Evaluation and Management Services in a Nursing Facility (L36230), Effective for services performed on or after 11/15/15, Revised for services performed on or after 01/08/19; 14) First Coast Local Coverage Article: Billing and Coding: Evaluation and Management Services in a Nursing Facility (A57724), Effective 10/03/18	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator "1" and/or "3" for TC component only. Services billed incorrectly will result in an overpayment and recoupment.	0062 - Radiology: Technical Component during Inpatient Stay	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 13 Radiology Services and Other Diagnostic Procedures, § 20.2.1 Hospital and Skilled Nursing Facility (SNF) Patients; 7) Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, § 10.7 – Type of Service	Automated	9/8/2017	Approved
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator "1" and/or "3" for TC component only. Services billed incorrectly will result in an overpayment and recoupment.	0062 - Radiology: Technical Component during Inpatient Stay	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 13 Radiology Services and Other Diagnostic Procedures, § 20.2.1 Hospital and Skilled Nursing Facility (SNF) Patients; 7) Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, § 10.7 – Type of Service	Automated	9/8/2017	Approved
Duplicate claims or line date of service items will be denied.	0064 - Facility Duplicate Claims	Inpatient Hospital; Outpatient Hospital; Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e) Payment of Benefits; 3) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, §120.2- Detection of Duplicate Claims- Exact Duplicates; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests	Automated	9/8/2017	Approved
Duplicate claims or line date of service items will be denied.	0064 - Facility Duplicate Claims	Inpatient Hospital; Outpatient Hospital; Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e) Payment of Benefits; 3) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, §120.2- Detection of Duplicate Claims- Exact Duplicates; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Services found to be not medically reasonable and necessary will be recouped and result in an overpayment.	0067 - Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements	Inpatient Hospital (IP); Inpatient Psychiatric Facility (IPF)	3 years prior to ADR Letter date	2 – all applicable states	1) Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 2) Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as Secondary Payer; 3) Title XVIII of the Social Security Act (SSA), Section 1814(a)(2)(A) and (4)- Conditions of Limitations on Payment for Services; 4) Title XVIII of the Social Security Act (SSA), Section 1835(a)- Procedure for Payment of Claims of Providers of Services; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) 42 CFR 409.62- Lifetime Maximum on Inpatient Psychiatric Care; 8) 42 CFR 412.404- Conditions for Payment under the Prospective Payment System for Inpatient Hospital Services of Psychiatric Facilities; 9) 42 CFR 424.14- Requirements for Inpatient Services of Inpatient Psychiatric Facilities; 10) 42 CFR 412.27(c)(3), (4) and (5)- Excluded Psychiatric Units: Additional Requirements; 11) 42 CFR 482.61- Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals; 12) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 13) Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, section 10.9- Inpatient Psychiatric Facility Services Certification and Recertification; 14) Medicare Benefit Policy Manual, Chapter 2- Inpatient Psychiatric Hospital Services, section 20- Admission Requirements; section 30- Medical Records Requirements; section 30.1- Development of Assessment/Diagnostic Data; section 30.2- Psychiatric Evaluation; section 30.2.1- Certification and Recertification Requirements; section 30.2.1.1- Certification; section 30.2.1.2- Recertification; section 30.2.1.3- Delayed/Lapsed Certification and Recertification; section 30.3- Treatment Plan; section 30.3.1- Individualized Treatment or Diagnostic Plan; section 30.3.2- Services Expected to Improve the Condition or for Purpose of Diagnosis; section 30.4 - Recording Progress; section 30.5- Discharge Planning and Discharge Summary; 15) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, section 190- Inpatient Psychiatric Facility Prospective Payment System (IPF PPS); 16) American Psychiatric Association Diagnostic and Statistical Manual, Text Revision, Fifth Edition; 17) ICD-10-CM codebook, Chapter 5- Mental Disorders; 18) Inpatient Psychiatric Facility PPS FY Addendum A Final PPS Payment Updates	Complex	9/8/2017	Approved
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Services found to be not medically reasonable and necessary will be recouped and result in an overpayment.	0067 - Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements	Inpatient Hospital (IP); Inpatient Psychiatric Facility (IPF)	3 years prior to ADR Letter date	3 – all applicable states	1) Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 2) Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as Secondary Payer; 3) Title XVIII of the Social Security Act (SSA), Section 1814(a)(2)(A) and (4)- Conditions of Limitations on Payment for Services; 4) Title XVIII of the Social Security Act (SSA), Section 1835(a)- Procedure for Payment of Claims of Providers of Services; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) 42 CFR 409.62- Lifetime Maximum on Inpatient Psychiatric Care; 8) 42 CFR 412.404- Conditions for Payment under the Prospective Payment System for Inpatient Hospital Services of Psychiatric Facilities; 9) 42 CFR 424.14- Requirements for Inpatient Services of Inpatient Psychiatric Facilities; 10) 42 CFR 412.27(c)(3), (4) and (5)- Excluded Psychiatric Units: Additional Requirements; 11) 42 CFR 482.61- Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals; 12) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 13) Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, section 10.9- Inpatient Psychiatric Facility Services Certification and Recertification; 14) Medicare Benefit Policy Manual, Chapter 2- Inpatient Psychiatric Hospital Services, section 20- Admission Requirements; section 30- Medical Records Requirements; section 30.1- Development of Assessment/Diagnostic Data; section 30.2- Psychiatric Evaluation; section 30.2.1- Certification and Recertification Requirements; section 30.2.1.1- Certification; section 30.2.1.2- Recertification; section 30.2.1.3- Delayed/Lapsed Certification and Recertification; section 30.3- Treatment Plan; section 30.3.1- Individualized Treatment or Diagnostic Plan; section 30.3.2- Services Expected to Improve the Condition or for Purpose of Diagnosis; section 30.4 - Recording Progress; section 30.5- Discharge Planning and Discharge Summary; 15) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, section 190- Inpatient Psychiatric Facility Prospective Payment System (IPF PPS); 16) American Psychiatric Association Diagnostic and Statistical Manual, Text Revision, Fifth Edition; 17) ICD-10-CM codebook, Chapter 5- Mental Disorders; 18) Inpatient Psychiatric Facility PPS FY Addendum A Final PPS Payment Updates	Complex	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Hospital emergency department services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider (based on Tax ID and Provider Specialty Code).	0070 - Critical Care Billed on the Same Day as Emergency Room Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual: Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 7) Medicare Claims Processing Manual: Chapter 12- 30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Service); 8) Medicare Claims Processing Manual: Chapter 12- §30.6.12 (for dates prior to 5/9/2021) – Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292), Section (H)- Critical Care Services and Other Evaluation and Management Services Provided on Same Day and Section (I) – Critical Care Services Provided by Physicians in Group Practice(s); 9) CPT Manual	Automated	10/5/2017	Approved
Hospital emergency department services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider (based on Tax ID and Provider Specialty Code).	0070 - Critical Care Billed on the Same Day as Emergency Room Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual: Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 7) Medicare Claims Processing Manual: Chapter 12- 30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Service); 8) Medicare Claims Processing Manual: Chapter 12- §30.6.12 (for dates prior to 5/9/2021) – Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292), Section (H)- Critical Care Services and Other Evaluation and Management Services Provided on Same Day and Section (I) – Critical Care Services Provided by Physicians in Group Practice(s); 9) CPT Manual	Automated	10/5/2017	Approved
Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected.	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B, TOB: 12x, 13x	3 years prior to the Informational Letter date	2 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicates- Submission of Institutional Claims; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3 (B)- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Services; 8) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 9) Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §200.2- Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD); 10) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; 11) Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; 12) Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 13) Medical Benefit Policy Manual, Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; 14) Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service and §20- Coverage Guidelines for Ambulance Service Claims; 15) Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected.	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B, TOB: 12x, 13x	3 years prior to the Informational Letter date	3 - all applicable states	1) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicates- Submission of Institutional Claims; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3 (B)- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Services; 8) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 9) Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §200.2- Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD); 10) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; 11) Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; 12) Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 13) Medical Benefit Policy Manual, Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; 14) Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service and §20- Coverage Guidelines for Ambulance Service Claims; 15) Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017	Approved
Medicare only pays for services that are reasonable and necessary for the setting billed. The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for beneficiaries who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. In order for IRF care to be considered reasonable and necessary, the documentation in the beneficiary's IRF medical record must demonstrate a reasonable expectation that CMS criteria, as defined in 42 C.F.R. §§412.600-622 and CMS Pub. 100-02, Ch. 1 section 110, was met at the time of admission to the IRF. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment	0073 - Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements	Inpatient Rehabilitation Facility; Inpatient	3 years prior to ADR Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR 405.986- Good Cause for Reopening; 5) 42 CFR 412.604(c)- Completion of patient assessment instrument; 6) 42 CFR 412.29- Classification criteria for payment under the inpatient rehabilitation facility prospective payment system; 7) 42 CFR 412.622- Basis of Payment, (a)- Method of Payment, (3)- IRF Coverage Criteria, (4)- Documentation, and (5)- Interdisciplinary Team Approach to Care; 8) Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered Under Part A, §110 – Inpatient Rehabilitation Facility (IRF) Services; 9) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.3- Documentation Requirements for Therapy Services; 10) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §140.3- Billing Requirements Under IRF PPS; 11) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 13) Change Request 12353, Pub 100-02 Medicare Benefit Policy, Transmittal 10892: https://www.cms.gov/files/document/r10892bp.pdf	Complex	10/4/2018	Approved
Medicare only pays for services that are reasonable and necessary for the setting billed. The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for beneficiaries who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. In order for IRF care to be considered reasonable and necessary, the documentation in the beneficiary's IRF medical record must demonstrate a reasonable expectation that CMS criteria, as defined in 42 C.F.R. §§412.600-622 and CMS Pub. 100-02, Ch. 1 section 110, was met at the time of admission to the IRF. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment	0073 - Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements	Inpatient Rehabilitation Facility; Inpatient	3 years prior to ADR Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR 405.986- Good Cause for Reopening; 5) 42 CFR 412.604(c)- Completion of patient assessment instrument; 6) 42 CFR 412.29- Classification criteria for payment under the inpatient rehabilitation facility prospective payment system; 7) 42 CFR 412.622- Basis of Payment, (a)- Method of Payment, (3)- IRF Coverage Criteria, (4)- Documentation, and (5)- Interdisciplinary Team Approach to Care; 8) Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered Under Part A, §110 – Inpatient Rehabilitation Facility (IRF) Services; 9) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.3- Documentation Requirements for Therapy Services; 10) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §140.3- Billing Requirements Under IRF PPS; 11) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 13) Change Request 12353, Pub 100-02 Medicare Benefit Policy, Transmittal 10892: https://www.cms.gov/files/document/r10892bp.pdf	Complex	10/4/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Drugs and Biologicals are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that CPT/HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Effective January 1, 2017, when processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors shall require the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.	0074 - Drugs and Biologicals: Incorrect Units Billed	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, 10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"; 7) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services; §50.3- Incident to Requirements; §60.1.A- Commonly Furnished in Physicians' Offices; 8) Medicare Alpha-Numeric HCPCS File; 9) Annual American Medical Association: CPT Manual; 10) Annual HCPCS Level II Manual; 11) Medicare Part B Drug Average Sales Price; ASP Pricing File; 12) U.S. National Library of Medicine DailyMed	Complex	12/21/2017	Approved
Drugs and Biologicals are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that CPT/HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Effective January 1, 2017, when processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors shall require the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.	0074 - Drugs and Biologicals: Incorrect Units Billed	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, 10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"; 7) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services; §50.3- Incident to Requirements; §60.1.A- Commonly Furnished in Physicians' Offices; 8) Medicare Alpha-Numeric HCPCS File; 9) Annual American Medical Association: CPT Manual; 10) Annual HCPCS Level II Manual; 11) Medicare Part B Drug Average Sales Price; ASP Pricing File; 12) U.S. National Library of Medicine DailyMed	Complex	12/21/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The Annual Wellness Visit (AWV) is not payable if an Initial Preventive Physical Examination (IPPE) has been paid within the previous eleven (11) whole months.	0077 - Annual Wellness Visit Billed Sooner Than Eleven Whole Months Following the Initial Preventive Physical Examination	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 7) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(15), (16)- Any Services that are not Reasonable and Necessary, (15)-additional preventive services; (16) Annual Wellness Visit with PPE; 8) Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV)	Automated	1/9/2018	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventive Physical Examination (IPPE) has been paid within the previous eleven (11) whole months.	0077 - Annual Wellness Visit Billed Sooner Than Eleven Whole Months Following the Initial Preventive Physical Examination	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 7) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(15), (16)- Any Services that are not Reasonable and Necessary, (15)-additional preventive services; (16) Annual Wellness Visit with PPE; 8) Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV)	Automated	1/9/2018	Approved
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Cardiac Pacemakers: Medical Necessity and Documentation Requirements	Outpatient Hospital (OP), Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3- Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; 7) CGS Local Coverage Article A54961- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 05/01/2016; Revised 01/01/2020; 8) Cahaba Local Coverage Article A54949- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Retired 01/29/2018; 9) First Coast Local Coverage Article A54926- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 10) NGS Local Coverage Article A54909- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 4/15/2016; Revised 5/7/2020; 11) Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Revised 10/01/2019; 12) Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016, Revised 10/01/2019; 13) Novitas Local Coverage Article A54982- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 14) Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 11/7/2019; 15) WPS Local Coverage Article A54958- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/15/2016; Revised 11/01/2019; 16) Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Cardiac Pacemakers: Medical Necessity and Documentation Requirements	Outpatient Hospital (OP), Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3- Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; 7) CGS Local Coverage Article A54961- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 05/01/2016; Revised 01/01/2020; 8) Cahaba Local Coverage Article A54949- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Retired 01/29/2018; 9) First Coast Local Coverage Article A54926- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 10) NGS Local Coverage Article A54909- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 4/15/2016; Revised 5/7/2020; 11) Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Revised 10/01/2019; 12) Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016, Revised 10/01/2019; 13) Novitas Local Coverage Article A54982- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 14) Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 11/7/2019; 15) WPS Local Coverage Article A54958- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/15/2016; Revised 11/01/2019; 16) Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the finding is billed on the same claim line with units greater than 1 (for the same eye). Provider is entitled to payment for one eye and only a partial payment will be recovered.	0083 - Cataract Removal Excessive Units - Partial Denial	Professional Services (Physician/Non-Physician Practitioner), Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D Ophthalmology); 7) CGS LCA A56453 – Billing and Coding: Cataract Extraction, Effective 10/01/16; 8) NGS LCA A56544 – Billing and Coding: Cataract Extraction, Effective 08/01/19; 9) Novitas LCA A56615 – Billing and Coding: Cataract Extraction (including Complex Cataract Surgery), Effective 06/13/19; 10) Palmetto LCA A56613 – Billing and Coding Cataract Surgery, Effective 06/13/19; 11) Noridian LCA A57195 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; 12) Noridian LCA A57196 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; 13) Palmetto LCA A53047 – Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation, Effective 10/01/15	Automated	3/14/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the finding is billed on the same claim line with units greater than 1 (for the same eye). Provider is entitled to payment for one eye and only a partial payment will be recovered.	0083 - Cataract Removal Excessive Units - Partial Denial	Professional Services (Physician/Non-Physician Practitioner), Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D Ophthalmology); 7) CGS LCA A56453 – Billing and Coding: Cataract Extraction, Effective 10/01/16; 8) NGS LCA A56544 – Billing and Coding: Cataract Extraction, Effective 08/01/19; 9) Novitas LCA A56615 – Billing and Coding: Cataract Extraction (including Complex Cataract Surgery), Effective 06/13/19; 10) Palmetto LCA A56613 – Billing and Coding Cataract Surgery, Effective 06/13/19; 11) Noridian LCA A57195 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; 12) Noridian LCA A57196 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; 13) Palmetto LCA A53047 – Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation, Effective 10/01/15	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye will be denied. This new issue indicates that findings are across claims, for the same eye, and the finding claim line is a Full recovery.	0084 - Cataract Removal: Duplicate Payment	Professional Services (Physician/Non-Physician Practitioner), Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8- Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000 – 69999, Section D - Ophthalmology	Automated	3/14/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye will be denied. This new issue indicates that findings are across claims, for the same eye, and the finding claim line is a Full recovery.	0084 - Cataract Removal: Duplicate Payment	Professional Services (Physician/Non-Physician Practitioner), Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8- Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000 – 69999, Section D - Ophthalmology	Automated	3/14/2018	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services. Denied services will result in an overpayment.	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory, Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 8) Current Procedural Terminology Coding Book	Automated	3/13/2018	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services. Denied services will result in an overpayment.	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory, Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 8) Current Procedural Terminology Coding Book	Automated	3/13/2018	Approved
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) Codes Billed Same Day as Inpatient Admission	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.8(D)- Admission to Inpatient Status Following Observation Care	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) Codes Billed Same Day as Inpatient Admission	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 7) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.8(D)- Admission to Inpatient Status Following Observation Care	Automated	3/14/2018	Approved
The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these laboratory services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system.	0087 - Laboratory Services for End-Stage Renal Disease Subject to Part B Consolidated Billing: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.929- Post-Payment Review; 4) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8) Medicare Benefit Policy Manual, Chapter 11- End Stage Renal Disease, §20.2- Laboratory Services; 9) Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 10) ESRD PPS Consolidated Billing- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018	Approved
The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these laboratory services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system.	0087 - Laboratory Services for End-Stage Renal Disease Subject to Part B Consolidated Billing: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.929- Post-Payment Review; 4) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8) Medicare Benefit Policy Manual, Chapter 11- End Stage Renal Disease, §20.2- Laboratory Services; 9) Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 10) ESRD PPS Consolidated Billing- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018	Approved
Covered ancillary items and services are not payable if there is no approved Ambulatory Surgical Center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §260- Ambulatory Surgical Center Services; 7) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgery Centers, §40- Payment for Ambulatory Surgery; 8) CMS Ambulatory Surgery Center Approved HCPCS Code and Payment Rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/ASCPayment/11_Addenda_Updates	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Covered ancillary items and services are not payable if there is no approved Ambulatory Surgical Center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §260- Ambulatory Surgical Center Services; 7) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgery Centers, §40- Payment for Ambulatory Surgery; 8) CMS Ambulatory Surgery Center Approved HCPCS Code and Payment Rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/ASCPayment/11_Addenda_Updates	Automated	3/14/2018	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - Clinical Social Worker during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section §1861(hh)- Clinical Social Worker, (hh)(2)- Clinical Social Worker Services; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5) 42 CFR §405.929- Post-Payment Review; 6) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7) 42 CFR §405.986- Good Cause for Reopening; 8) 42 CFR §409.10(a)(4)- Included Services-Medical Social Services; 9) 42 CFR §410.73- Clinical Social Worker Services; 10) 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 11) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 13) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients	Automated	3/14/2018	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - Clinical Social Worker during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section §1861(hh)- Clinical Social Worker, (hh)(2)- Clinical Social Worker Services; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5) 42 CFR §405.929- Post-Payment Review; 6) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7) 42 CFR §405.986- Good Cause for Reopening; 8) 42 CFR §409.10(a)(4)- Included Services-Medical Social Services; 9) 42 CFR §410.73- Clinical Social Worker Services; 10) 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 11) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 13) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients	Automated	3/14/2018	Approved
The technical component (TC) of lab/pathology services furnished to patients in an inpatient or outpatient hospital setting are not separately payable.	0090 - Laboratory/Pathology Technical Component for Inpatient or Outpatient Hospitals: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Laboratory; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.929- Post-Payment Review; 4) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 9) Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements; Addendum – MPFSDB File Record Layout and Field Descriptions	Automated	4/4/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The technical component (TC) of lab/pathology services furnished to patients in an inpatient or outpatient hospital setting are not separately payable.	0090 - Laboratory/Pathology Technical Component for Inpatient or Outpatient Hospitals: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Laboratory; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.929- Post-Payment Review; 4) 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6) 42 CFR §405.986- Good Cause for Reopening; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 9) Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements; Addendum – MPFSDB File Record Layout and Field Descriptions	Automated	4/4/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in an overpayment.	0091- Duplicate Claims: Professional Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 7) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicates, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 8) Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioner, §20.4.2- Site of Service Payment Differential; 9) Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes (POS) and Definitions	Automated	5/8/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in an overpayment.	0091- Duplicate Claims: Professional Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 7) Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicates, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 8) Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioner, §20.4.2- Site of Service Payment Differential; 9) Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes (POS) and Definitions	Automated	5/8/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode when the record demonstrates either transcutaneous placement of a device or percutaneous placement without identification of the selected (peripheral or cranial) nerve.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare National Coverage Determination Manual, Chapter 1, Part 1, §30.3- Acupuncture; 7) Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.7.1- Assessing Patients Suitability for Electrical Nerve Stimulation Therapy; 8) Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L34328 Peripheral Nerve Stimulation Original Effective Date: 10/01/2015, Revised 12/01/2019; 9) Noridian Healthcare Solutions, LLC LCD L37360 Peripheral Nerve Stimulation Original Effective Date: 08/27/2018; Revised 12/01/19; 10) Wisconsin Physicians Service Insurance Corporation Local Coverage Article (LCA) A56062 Billing and Coding Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT) Original Effective Date: 8/01/2018, Revised 070/30/20; 11) Novitas Solutions, Inc., LCA A55240 Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device), Original Effective Date 08/11/2016, Revised 01/21/20; 12) Noridian Healthcare Solutions, LLC LCA A55530 Billing and Coding Peripheral Nerve Stimulation (JE) Original Effective Date: 8/27/2018, Revised 10/01/21; 13) Noridian Healthcare Solutions, LLC LCA A55531 Billing and Coding: Peripheral Nerve Stimulation (JF) Original Effective Date: 8/27/2018, Revised 10/01/21; 14) First Coast Service Options, Inc LCA A54794 Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) Original Effective Date: 12/24/2015; 15) American Medical Association Current Procedural Terminology Manual Healthcare Common Procedure Coding System, 2014 to current	Complex	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode when the record demonstrates either transcutaneous placement of a device or percutaneous placement without identification of the selected (peripheral or cranial) nerve.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare National Coverage Determination Manual, Chapter 1, Part 1, §30.3- Acupuncture; 7) Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.7.1- Assessing Patients Suitability for Electrical Nerve Stimulation Therapy; 8) Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L34328 Peripheral Nerve Stimulation Original Effective Date: 10/01/2015, Revised 12/01/2019; 9) Noridian Healthcare Solutions, LLC LCD L37360 Peripheral Nerve Stimulation Original Effective Date: 08/27/2018; Revised 12/01/19; 10) Wisconsin Physicians Service Insurance Corporation Local Coverage Article (LCA) A56062 Billing and Coding Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT) Original Effective Date: 8/01/2018, Revised 070/30/20; 11) Novitas Solutions, Inc., LCA A55240 Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device), Original Effective Date 08/11/2016, Revised 01/21/20; 12) Noridian Healthcare Solutions, LLC LCA A55530 Billing and Coding Peripheral Nerve Stimulation (JE) Original Effective Date: 8/27/2018, Revised 10/01/21; 13) Noridian Healthcare Solutions, LLC LCA A55531 Billing and Coding: Peripheral Nerve Stimulation (JF) Original Effective Date: 8/27/2018, Revised 10/01/21; 14) First Coast Service Options, Inc LCA A54794 Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) Original Effective Date: 12/24/2015; 15) American Medical Association Current Procedural Terminology Manual Healthcare Common Procedure Coding System, 2014 to current	Complex	5/8/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, ASC, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 9) Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 10) First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 11) NGS Local Coverage Article A56326- Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 12) Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 13) Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 14) Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 15) Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 16) WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	5/14/2018	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, ASC, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 9) Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 10) First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 11) NGS Local Coverage Article A56326- Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 12) Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 13) Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 14) Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 15) Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 16) WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	5/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Certain CPT codes for Part B Professional services for the same Beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care. These services are included in the critical care service and should not be reported separately.	0098 - Critical Care Professional Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, § 30.6.12 (J) – Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291-99292	Automated	6/18/2018	Approved
Certain CPT codes for Part B Professional services for the same Beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care. These services are included in the critical care service and should not be reported separately.	0098 - Critical Care Professional Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, § 30.6.12 (J) – Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291-99292	Automated	6/18/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services, listed in the SNF Consolidated Billing Table, Major Category I.F and V.A., provided to beneficiaries by the outpatient facility, in a Medicare covered Part A SNF stay, are included in a bundled prospective payment and are not separately payable. Payment for those services will be recouped as identified overpayments.	0099 - Skilled Nursing Facility Consolidated Billing: Unbundling	Outpatient Facility	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing; §§10-10.4- Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview; §§20- 20.6- Services Included in Part A PPS Payment Not Billable Separately by the SNF; 7) CMS SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	6/25/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services, listed in the SNF Consolidated Billing Table, Major Category I.F and V.A., provided to beneficiaries by the outpatient facility, in a Medicare covered Part A SNF stay, are included in a bundled prospective payment and are not separately payable. Payment for those services will be recouped as identified overpayments.	0099 - Skilled Nursing Facility Consolidated Billing: Unbundling	Outpatient Facility	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing; §§10-10.4- Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview; §§20- 20.6- Services Included in Part A PPS Payment Not Billable Separately by the SNF; 7) CMS SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	6/25/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied.	0100 - Add-On Code Paid without Primary Code and/or Denied Primary Code: Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code (Rev. 10742, Issued: 05/03/21, Effective: 05/09/21, Implementation: 05/09/21); 7) Medicare Claims Processing Manual Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9) Medicare Claims Processing Manual, Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 10) National Correct Coding Initiative, Add-on Code Edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	6/20/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied.	0100 - Add-On Code Paid without Primary Code and/or Denied Primary Code: Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4) 42 CFR §405.986- Good Cause for Reopening; 5) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6) Medicare Claims Processing Manual, Chapter 12- physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code (Rev. 10742, Issued: 05/03/21, Effective: 05/09/21, Implementation: 05/09/21); 7) Medicare Claims Processing Manual Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9) Medicare Claims Processing Manual, Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 10) National Correct Coding Initiative, Add-on Code Edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	6/20/2018	Approved
APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the APC by reviewing the billed services affecting or potentially affecting APC reimbursement.	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	7/26/2018	Approved
APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the APC by reviewing the billed services affecting or potentially affecting APC reimbursement.	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	7/26/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also paid. ASC providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied. Denials will result in an overpayment.	0104 - Add-on Codes Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	7/24/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also paid. ASC providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied. Denials will result in an overpayment.	0104 - Add-on Codes Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	7/24/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Physician services billed during an active hospice period should be paid by the Hospice provider if services are related to the hospice beneficiary's terminal condition or if a physician is employed or paid under arrangement by the beneficiary's hospice provider. Medicare should not be billed for either of the aforementioned scenarios. Denied services will result in an overpayment.	0105 - Physician Services during Hospice Period: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	8/14/2018	Approved
Physician services billed during an active hospice period should be paid by the Hospice provider if services are related to the hospice beneficiary's terminal condition or if a physician is employed or paid under arrangement by the beneficiary's hospice provider. Medicare should not be billed for either of the aforementioned scenarios. Denied services will result in an overpayment.	0105 - Physician Services during Hospice Period: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	8/14/2018	Approved
Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings. The rate, facility or nonfacility, which a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. Physician services identified by this audit and with a facility/non-facility rate differential will be repriced and may result in an overpayment or underpayment.	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	9/11/2018	Approved
Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings. The rate, facility or nonfacility, which a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. Physician services identified by this audit and with a facility/non-facility rate differential will be repriced and may result in an overpayment or underpayment.	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	9/11/2018	Approved
Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A stay are included in a bundled prospective payment made through the fiscal intermediary (FI) A/B Medicare Admin. Contractor (MAC) to the SNF. These bundled services are to be billed by the SNF to the FI A/B MAC in a consolidated bill. The consolidated billing requirements confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay. Unbundled services will be recouped and result in an overpayment.	0109 - Skilled Nursing Facility (SNF) Consolidated Billing Part B (Full)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	9/20/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A stay are included in a bundled prospective payment made through the fiscal intermediary (FI) A/B Medicare Admin. Contractor (MAC) to the SNF. These bundled services are to be billed by the SNF to the FI A/B MAC in a consolidated bill. The consolidated billing requirements confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay. Unbundled services will be recouped and result in an overpayment.	0109 - Skilled Nursing Facility (SNF) Consolidated Billing Part B (Full)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	9/20/2018	Approved
When a Part B CPT/HCPCS code listed on File 2 (Professional Components of Services to be Submitted with a 26 Modifier) is billed during a paid inpatient Part A SNF stay, without modifier 26, the Part B claim will be repriced with modifier 26 to reflect the professional component reduction. The overpayment is identified by the difference between the original paid Part B amount and the re-calculated paid amount based on modifier 26 pricing.	0110 - Skilled Nursing Facility Consolidated Billing: Part B – Use of Modifier 26, Professional Component	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	9/20/2018	Approved
When a Part B CPT/HCPCS code listed on File 2 (Professional Components of Services to be Submitted with a 26 Modifier) is billed during a paid inpatient Part A SNF stay, without modifier 26, the Part B claim will be repriced with modifier 26 to reflect the professional component reduction. The overpayment is identified by the difference between the original paid Part B amount and the re-calculated paid amount based on modifier 26 pricing.	0110 - Skilled Nursing Facility Consolidated Billing: Part B – Use of Modifier 26, Professional Component	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	9/20/2018	Approved
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary. Services that are determined to be not medically reasonable and necessary will result in an overpayment.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, SNF	3 years prior to ADR Letter date	2 – all applicable states		Complex	9/28/2018	Approved
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary. Services that are determined to be not medically reasonable and necessary will result in an overpayment.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, SNF	3 years prior to ADR Letter date	3 – all applicable states		Complex	9/28/2018	Approved
A Monthly Capitation Payment (MCP) is a payment made to physicians for most dialysis-related physician services furnished to Medicare End Stage Renal Disease (ESRD) patients on a monthly basis. The same monthly amount is paid to the physician for each patient supervised regardless of whether the patient dialyzes at home or as an outpatient in an approved ESRD facility. The claim/claim line with a single paid unit of 90957 or 90960 is the covered service. All additional claim(s)/claim line(s) of 90957-90962, are the overpayments and will be recovered in full.	0112 - Monthly Capitation Payment for End-Stage Renal Disease: 4 or More Visits per Month	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	11/7/2018	Approved
A Monthly Capitation Payment (MCP) is a payment made to physicians for most dialysis-related physician services furnished to Medicare End Stage Renal Disease (ESRD) patients on a monthly basis. The same monthly amount is paid to the physician for each patient supervised regardless of whether the patient dialyzes at home or as an outpatient in an approved ESRD facility. The claim/claim line with a single paid unit of 90957 or 90960 is the covered service. All additional claim(s)/claim line(s) of 90957-90962, are the overpayments and will be recovered in full.	0112 - Monthly Capitation Payment for End-Stage Renal Disease: 4 or More Visits per Month	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	11/7/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. Providers cannot billed for services that are rendered. Physician claims billed with a home-related place of service that overlaps an inpatient hospital stay will be denied.	0115 - Physician Claims with Place of Service Home Overlapping Inpatient Hospital Stay: Services Billed Not Rendered	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	10/17/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. Providers cannot billed for services that are rendered. Physician claims billed with a home-related place of service that overlaps an inpatient hospital stay will be denied.	0115 - Physician Claims with Place of Service Home Overlapping Inpatient Hospital Stay: Services Billed Not Rendered	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	10/17/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
HCPCS Codes with a PC/TC Indicator of "1" and billed with either 26 or TC in any modifier field should be paid at either the technical component or the professional component rate based on the modifier billed. Overpayments occur when the applicable Medicare Physician Fee Schedule amount for Modifier TC and/or 26 are not applied. Findings will be the difference between the original Provider Paid Amount and the Re-Calculated Provider Paid Amount.	0116 - Modifiers TC and 26: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	10/9/2018	Approved
HCPCS Codes with a PC/TC Indicator of "1" and billed with either 26 or TC in any modifier field should be paid at either the technical component or the professional component rate based on the modifier billed. Overpayments occur when the applicable Medicare Physician Fee Schedule amount for Modifier TC and/or 26 are not applied. Findings will be the difference between the original Provider Paid Amount and the Re-Calculated Provider Paid Amount.	0116 - Modifiers TC and 26: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	10/9/2018	Approved
If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, at the same encounter, the limited debridement (code 29822) is not separately payable and Current Procedural Terminology (CPT) code 29822 will be denied. "Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure." Unbundled services will be denied and result in an overpayment.	0117 - Arthroscopic Limited Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient (Outpatient for claims prior to 10/01/2017. After 10/01/2017, denial of 29822 made no change in APC). It is for all physician/ nonphysician in the usual time frame but in Outpatient facility, it must be restricted to claims rendered prior to 10/1/2017 due to change from T (multiple surg payment) to J1 (APC payment).	3 years prior to the Informational Letter date	2 – all applicable states		Automated	10/17/2018	Approved
If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, at the same encounter, the limited debridement (code 29822) is not separately payable and Current Procedural Terminology (CPT) code 29822 will be denied. "Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure." Unbundled services will be denied and result in an overpayment.	0117 - Arthroscopic Limited Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient (Outpatient for claims prior to 10/01/2017. After 10/01/2017, denial of 29822 made no change in APC). It is for all physician/ nonphysician in the usual time frame but in Outpatient facility, it must be restricted to claims rendered prior to 10/1/2017 due to change from T (multiple surg payment) to J1 (APC payment).	3 years prior to the Informational Letter date	3 – all applicable states		Automated	10/17/2018	Approved
Shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder. If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, on the same date of service, the extensive debridement (code 29823) is not separately payable and CPT code 29823 will be denied. Separate reporting of extensive debridement only applies to three CPT codes: 29824, 29827, and 29828. Unbundled services will be denied and result in an overpayment.	0118 - Arthroscopic Extensive Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital (For claims prior to 10/01/2017. After 10/01/2017, denial of 29823 made no change in APC.)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	10/16/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder. If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, on the same date of service, the extensive debridement (code 29823) is not separately payable and CPT code 29823 will be denied. Separate reporting of extensive debridement only applies to three CPT codes: 29824, 29827, and 29828. Unbundled services will be denied and result in an overpayment.	0118 - Arthroscopic Extensive Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital (For claims prior to 10/01/2017. After 10/01/2017, denial of 29823 made no change in APC.)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	10/16/2018	Approved
Lumbar epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of entry. These are termed the interlaminar, caudal, and transforaminal approaches. The procedures involve the injection of a solution containing local anesthetic with or without corticosteroids. In order to be considered medically necessary, they must meet certain indications and procedural requirements.	0119 - Transforaminal Epidural Steroid Injection: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	10/31/2018	Approved
Based on CPT Code descriptions, CPT Code 17000 may only be billed once per date of service; CPT Code 17003 may only be billed thirteen times per date of service and CPT Code 17004 may only be billed once per date of service. CPT codes 17000, 17003 and/or 17004 are overpayments, if billed in excess of units described above and will be recovered.	0121 - Destruction of Premalignant Lesions: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	12/4/2018	Approved
Based on CPT Code descriptions, CPT Code 17000 may only be billed once per date of service; CPT Code 17003 may only be billed thirteen times per date of service and CPT Code 17004 may only be billed once per date of service. CPT codes 17000, 17003 and/or 17004 are overpayments, if billed in excess of units described above and will be recovered.	0121 - Destruction of Premalignant Lesions: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	12/4/2018	Approved
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. Identified unbundled services will be denied and may result in an overpayment.	0122 - Outpatient Service Related to Hospice Diagnosis: Unbundling	Part A Outpatient	3 years prior to the Informational Letter date	2 – all applicable states		Automated	11/29/2018	Approved
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. Identified unbundled services will be denied and may result in an overpayment.	0122 - Outpatient Service Related to Hospice Diagnosis: Unbundling	Part A Outpatient	3 years prior to the Informational Letter date	3 – all applicable states		Automated	11/29/2018	Approved
When billed on the same date of service as an inpatient hospital claim, the Technical Component (TC) of diagnostics is not payable to the Part B provider. The technical component is performed by the facility while a patient is in a covered Part A Inpatient Stay. Incorrect billing of the technical component will be denied.	0123 - Technical Component of Diagnostic Procedures During Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	12/11/2018	Approved
When billed on the same date of service as an inpatient hospital claim, the Technical Component (TC) of diagnostics is not payable to the Part B provider. The technical component is performed by the facility while a patient is in a covered Part A Inpatient Stay. Incorrect billing of the technical component will be denied.	0123 - Technical Component of Diagnostic Procedures During Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	12/11/2018	Approved
HCPCS/CPT Codes with a PC/TC Indicator "7" in the Medicare Physician Fee Schedule Data Base payment may not be made if the service is provided to a hospital inpatient by a physical therapist, occupational therapist, or speech language therapist in private practice. Unbundled services will be denied and result in an overpayment.	0124 - Part B Therapies during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	11/30/2018	Approved
HCPCS/CPT Codes with a PC/TC Indicator "7" in the Medicare Physician Fee Schedule Data Base payment may not be made if the service is provided to a hospital inpatient by a physical therapist, occupational therapist, or speech language therapist in private practice. Unbundled services will be denied and result in an overpayment.	0124 - Part B Therapies during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	11/30/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare reimbursement for telehealth services include subsequent hospital care services and subsequent nursing facility care services. However, subsequent hospital care visits are limited to one telehealth visit every three days for hospital inpatients and one subsequent nursing facility telehealth visit every 30 days for nursing facility resident/for the same provider based on same Provider Tax Identification Number (TIN) and Provider Specialty Code. Line items billed in excess of these parameters will be recouped.	0125 - Subsequent Hospital and Nursing Facility Care Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Critical Access Hospitals (CAHs); Type of Bill 85X Identified by revenue codes 96X, 97Xx or98X	3 years prior to the Informational Letter date	2 – all applicable states		Automated	2/21/2019	Approved
Medicare reimbursement for telehealth services include subsequent hospital care services and subsequent nursing facility care services. However, subsequent hospital care visits are limited to one telehealth visit every three days for hospital inpatients and one subsequent nursing facility telehealth visit every 30 days for nursing facility resident/for the same provider based on same Provider Tax Identification Number (TIN) and Provider Specialty Code. Line items billed in excess of these parameters will be recouped.	0125 - Subsequent Hospital and Nursing Facility Care Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Critical Access Hospitals (CAHs); Type of Bill 85X Identified by revenue codes 96X, 97Xx or98X	3 years prior to the Informational Letter date	3 – all applicable states		Automated	2/21/2019	Approved
Surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code shall not be reported with a surgical endoscopy code. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered shall be reported	0126 - Endoscopy Procedures: Diagnostic and Surgical Billed Same Day	Outpatient Facility; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	11/14/2018	Approved
Surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code shall not be reported with a surgical endoscopy code. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered shall be reported	0126 - Endoscopy Procedures: Diagnostic and Surgical Billed Same Day	Outpatient Facility; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	11/14/2018	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere pressure. The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30) days of treatment with standard wound therapy and must be used in addition to standard wound care. Medical records will be reviewed to determine if Hyperbaric Oxygen Therapy (HBOT) for diabetic wounds is medically necessary according to Medicare coverage indications. HBOT for diabetic wounds that do not meet Medicare guidelines will result in an improper payment.	0129 - Hyperbaric Oxygen Therapy for Diabetic Wounds: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	1/30/2019	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere pressure. The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30) days of treatment with standard wound therapy and must be used in addition to standard wound care. Medical records will be reviewed to determine if Hyperbaric Oxygen Therapy (HBOT) for diabetic wounds is medically necessary according to Medicare coverage indications. HBOT for diabetic wounds that do not meet Medicare guidelines will result in an improper payment.	0129 - Hyperbaric Oxygen Therapy for Diabetic Wounds: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	1/30/2019	Approved
Panniculectomy billed for cosmetic purposes will not be deemed medically necessary. In addition, panniculectomy billed at the same time as an open abdominal surgery, or if is incidental to another procedure, is not separately coded per Coding Guidelines.	0130 - Panniculectomy: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	2/13/2019	Approved
Panniculectomy billed for cosmetic purposes will not be deemed medically necessary. In addition, panniculectomy billed at the same time as an open abdominal surgery, or if is incidental to another procedure, is not separately coded per Coding Guidelines.	0130 - Panniculectomy: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	2/13/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CMS will not pay for an emergency department visit or an office visit E&M service on the same day as a comprehensive nursing facility assessment when both the E&M service and the comprehensive nursing facility assessment are performed by the same physician, at a site other than the nursing facility. The E&M service is bundled into the comprehensive nursing facility assessment code. The E&M service is not separately payable.	0132 - Evaluation and Management Same Day as Admission to a Nursing Facility: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	2/5/2019	Approved
CMS will not pay for an emergency department visit or an office visit E&M service on the same day as a comprehensive nursing facility assessment when both the E&M service and the comprehensive nursing facility assessment are performed by the same physician, at a site other than the nursing facility. The E&M service is bundled into the comprehensive nursing facility assessment code. The E&M service is not separately payable.	0132 - Evaluation and Management Same Day as Admission to a Nursing Facility: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	2/5/2019	Approved
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer). Claims billed without the required Tracer HCPCS codes will be recovered as overpayments.	0133 - Positron Emission Tomography Scans Paid without Tracer Codes-Independent Diagnostic Testing Facility: Non-Allowable Service	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	2 – all applicable states		Automated	2/5/2019	Approved
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer). Claims billed without the required Tracer HCPCS codes will be recovered as overpayments.	0133 - Positron Emission Tomography Scans Paid without Tracer Codes-Independent Diagnostic Testing Facility: Non-Allowable Service	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	3 – all applicable states		Automated	2/5/2019	Approved
Claims for Cryosurgery of the Prostate are deemed to be medically necessary for the indications listed in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, §230.9). Documentation will be reviewed to determine whether Cryosurgery of the Prostate Gland services met Medicare coverage criteria and were reasonable and necessary.	0134 - Cryosurgery of the Prostate: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	2/5/2019	Approved
Claims for Cryosurgery of the Prostate are deemed to be medically necessary for the indications listed in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, §230.9). Documentation will be reviewed to determine whether Cryosurgery of the Prostate Gland services met Medicare coverage criteria and were reasonable and necessary.	0134 - Cryosurgery of the Prostate: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	2/5/2019	Approved
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meets Federal guidelines and Medicare coverage criteria.	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	3/7/2019	Approved
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meets Federal guidelines and Medicare coverage criteria.	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	3/7/2019	Approved
Radiographs of the chest are common tests performed in many outpatient offices (radiology and many others), clinics, outpatient hospital departments, inpatient hospital episodes, skilled nursing facilities, homes, and other settings. They can be used for many pulmonary diseases, cardiac diseases, infections and inflammatory diseases, chest and upper abdominal trauma situations, malignant and metastatic diseases, allergic and drug related diseases. This review will ensure chest x-rays are paid when billed appropriately and only when medically necessary. Claims that are billed inappropriately or that do not meet medical necessity requirements will result in an overpayment.	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	4/15/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Radiographs of the chest are common tests performed in many outpatient offices (radiology and many others), clinics, outpatient hospital departments, inpatient hospital episodes, skilled nursing facilities, homes, and other settings. They can be used for many pulmonary diseases, cardiac diseases, infections and inflammatory diseases, chest and upper abdominal trauma situations, malignant and metastatic diseases, allergic and drug related diseases. This review will ensure chest x-rays are paid when billed appropriately and only when medically necessary. Claims that are billed inappropriately or that do not meet medical necessity requirements will result in an overpayment.	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	4/15/2019	Approved
Physical therapy, speech-language pathology services, and occupational therapy are bundled into the SNF's global per diem payment for a resident's covered Part A stay. They are also subject to the SNF "Part B" consolidated billing requirement for services furnished to SNF Part B residents.	0138 - Skilled Nursing Facility Consolidated Billing for Therapies: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Physical Therapist; Occupational Therapist; Speech-language Pathologist	3 years prior to the Informational Letter date	2 – all applicable states		Automated	2/20/2019	Approved
Physical therapy, speech-language pathology services, and occupational therapy are bundled into the SNF's global per diem payment for a resident's covered Part A stay. They are also subject to the SNF "Part B" consolidated billing requirement for services furnished to SNF Part B residents.	0138 - Skilled Nursing Facility Consolidated Billing for Therapies: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Physical Therapist; Occupational Therapist; Speech-language Pathologist	3 years prior to the Informational Letter date	3 – all applicable states		Automated	2/20/2019	Approved
Vertebroplasty and kyphoplasty will be reviewed for medical necessity whether billed as an initial procedure, a repeat procedure (beyond once in a lifetime) or if performed at more than one vertebral level. Services that were not medically reasonable and necessary will be denied and will result in an overpayment.	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	2/20/2019	Approved
Vertebroplasty and kyphoplasty will be reviewed for medical necessity whether billed as an initial procedure, a repeat procedure (beyond once in a lifetime) or if performed at more than one vertebral level. Services that were not medically reasonable and necessary will be denied and will result in an overpayment.	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	2/20/2019	Approved
Pulmonary rehabilitation is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical Documentation will be reviewed to determine if pulmonary rehabilitation is medically reasonable and necessary as well as meeting federal guidelines and Medicare coverage criteria.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	3/27/2019	Approved
Pulmonary rehabilitation is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical Documentation will be reviewed to determine if pulmonary rehabilitation is medically reasonable and necessary as well as meeting federal guidelines and Medicare coverage criteria.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	3/27/2019	Approved
Services provided by a freestanding non-hospital ASC (Ambulatory Surgery Center) are included under the SNF Consolidated Billing Provisions. Certain services are not payable because they are included in SNF Consolidated Billing. Codes found in the SNF Consolidated Billing – Part A MAC Updates are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	4/2/2019	Approved
Services provided by a freestanding non-hospital ASC (Ambulatory Surgery Center) are included under the SNF Consolidated Billing Provisions. Certain services are not payable because they are included in SNF Consolidated Billing. Codes found in the SNF Consolidated Billing – Part A MAC Updates are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	4/2/2019	Approved
Claims for ERFA and EVLT for Lower Extremity Varicose Veins are not deemed to be medically necessary will be denied based on the guidelines outlined in the respective MAC Jurisdiction LCD(s). Services that are not medically reasonable and necessary will be denied.	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity and Documentation Requirements	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner), and Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states		Complex	4/2/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for ERFA and EVLT for Lower Extremity Varicose Veins are not deemed to be medically necessary will be denied based on the guidelines outlined in the respective MAC Jurisdiction LCD(s). Services that are not medically reasonable and necessary will be denied.	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity and Documentation Requirements	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner), and Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states		Complex	4/2/2019	Approved
When a more extensive CT Scan is performed on the same site as a less extensive CT Scan, the less extensive CT Scan is bundled into the more extensive CT Scan.	0146 - Computed Tomography Scans: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states		Automated	3/27/2019	Approved
When a more extensive CT Scan is performed on the same site as a less extensive CT Scan, the less extensive CT Scan is bundled into the more extensive CT Scan.	0146 - Computed Tomography Scans: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states		Automated	3/27/2019	Approved
When a more extensive Magnetic Resonance Imaging is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI.	0147 - Magnetic Resonance Imaging Procedures: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states		Automated	3/29/2019	Approved
When a more extensive Magnetic Resonance Imaging is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI.	0147 - Magnetic Resonance Imaging Procedures: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states		Automated	3/29/2019	Approved
Per Medicare Claims Processing Manual Chapter 12, Section 30.6.9.2 (C), CMS does not reimburse both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. CPT codes 99231 – 99233 will be considered overpayments and will be recovered.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	4/22/2019	Approved
Per Medicare Claims Processing Manual Chapter 12, Section 30.6.9.2 (C), CMS does not reimburse both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. CPT codes 99231 – 99233 will be considered overpayments and will be recovered.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	4/22/2019	Approved
Mohs Micrographic Surgery is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. This review will verify that the physician who performs the Mohs surgery is acting as both surgeon and pathologist. Codes 17311 and 17313 are used for the first layer (stage) only and include the work of excision and pathology of up to five tissue blocks. These codes are not targeted as it is assumed all patients will have first stage but these codes may be used to validate that the physician is acting as both surgeon and pathologist. Reviewers will determine if the correct number of units have been billed for additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314. Billing of excessive or insufficient units or a change in coding could result in an over- or underpayment and will be adjusted accordingly.	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	4/30/2019	Approved
Mohs Micrographic Surgery is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. This review will verify that the physician who performs the Mohs surgery is acting as both surgeon and pathologist. Codes 17311 and 17313 are used for the first layer (stage) only and include the work of excision and pathology of up to five tissue blocks. These codes are not targeted as it is assumed all patients will have first stage but these codes may be used to validate that the physician is acting as both surgeon and pathologist. Reviewers will determine if the correct number of units have been billed for additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314. Billing of excessive or insufficient units or a change in coding could result in an over- or underpayment and will be adjusted accordingly.	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	4/30/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The Medicare Physician Fee Schedule (MPFS) is the primary method of payment for enrolled health care professionals. Documentation will be reviewed to determine if professional services that affecting MPGS payment meet Medicare coverage criteria and applicable coding guidelines. Adjustment or denial of a code could result in an under- or overpayment.	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	4/24/2019	Approved
The Medicare Physician Fee Schedule (MPFS) is the primary method of payment for enrolled health care professionals. Documentation will be reviewed to determine if professional services that affecting MPGS payment meet Medicare coverage criteria and applicable coding guidelines. Adjustment or denial of a code could result in an under- or overpayment.	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	4/24/2019	Approved
Ambulatory Surgical Center coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the CPT/HCPCS coding and associated modifiers by reviewing the procedures affecting or potentially affecting payment.	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgery Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states		Complex	5/28/2019	Approved
Ambulatory Surgical Center coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the CPT/HCPCS coding and associated modifiers by reviewing the procedures affecting or potentially affecting payment.	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgery Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states		Complex	5/28/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0154 - Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states		Complex	5/22/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0154 - Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states		Complex	5/22/2019	Approved
Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers. Documentation will be reviewed to determine if the billed procedures meets Medicare coverage criteria and applicable coding guidelines for the use of modifier 73.	0157 - Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states		Complex	6/28/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers. Documentation will be reviewed to determine if the billed procedures meets Medicare coverage criteria and applicable coding guidelines for the use of modifier 73.	0157 - Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states		Complex	6/28/2019	Approved
On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. Therapy services billed separately during a home health episode of care will be recouped as the services are bundled into the Home Health Consolidated billing payment.	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, SNF Outpatient, Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	2 – all applicable states		Automated	7/15/2019	Approved
On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. Therapy services billed separately during a home health episode of care will be recouped as the services are bundled into the Home Health Consolidated billing payment.	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, SNF Outpatient, Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	3 – all applicable states		Automated	7/15/2019	Approved
Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter. CPT codes 92133 and/or 92134 will be considered in this edit, if billed together during the same patient encounter, on the same date of service. Only one is allowed per day, therefore the less comprehensive CPT/HCPCS Code - 92134 will be recovered as an overpayment.	0159 - Ophthalmic Diagnostic CPT Codes: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	6/19/2019	Approved
Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter. CPT codes 92133 and/or 92134 will be considered in this edit, if billed together during the same patient encounter, on the same date of service. Only one is allowed per day, therefore the less comprehensive CPT/HCPCS Code - 92134 will be recovered as an overpayment.	0159 - Ophthalmic Diagnostic CPT Codes: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	6/19/2019	Approved
Medical documentation will be reviewed to determine if the use of intravenous immune globulin for the treatment of Autoimmune Blistering Diseases (AMBDs) meets Medicare coverage criteria and is reasonable and necessary. Services that are not medically necessary will result in an overpayment.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Freestanding Clinic; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	8/20/2019	Approved
Medical documentation will be reviewed to determine if the use of intravenous immune globulin for the treatment of Autoimmune Blistering Diseases (AMBDs) meets Medicare coverage criteria and is reasonable and necessary. Services that are not medically necessary will result in an overpayment.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Freestanding Clinic; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	8/20/2019	Approved
Documentation will be reviewed to determine if correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	11/18/2019	Approved
Documentation will be reviewed to determine if correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	11/18/2019	Approved
All diagnostic tests, including Computed Tomography (CT) Coronary Angiography, must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. The physician who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, as part of a routine physical checkup are excluded from coverage.	0162 - Computerized Tomography Coronary Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	7/22/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
All diagnostic tests, including Computed Tomography (CT) Coronary Angiography, must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. The physician who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, as part of a routine physical checkup are excluded from coverage.	0162 - Computerized Tomography Coronary Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	7/22/2019	Approved
Ambulance transports of a hospice patient, which are related to the terminal illness and occur after the effective date of election, are the responsibility of the hospice provider. Payment for the ambulance claim will be recouped if the above condition occurs and separate payment was paid to the provider.	0163 - Ambulance Services Billed During Hospice: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 – all applicable states		Automated	7/23/2019	Approved
Ambulance transports of a hospice patient, which are related to the terminal illness and occur after the effective date of election, are the responsibility of the hospice provider. Payment for the ambulance claim will be recouped if the above condition occurs and separate payment was paid to the provider.	0163 - Ambulance Services Billed During Hospice: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 – all applicable states		Automated	7/23/2019	Approved
A Bilateral Indicator of "3" indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with either a modifier 50 or modifiers RT and LT, and a '2' in the units field, reimbursement is based on 100% of the Medicare allowed amount for each side less any applicable multiple procedure pricing rules. This query identifies claims with underpayments due to code being submitted with a quantity of "2" when performed bilaterally.	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	9/24/2019	Approved
A Bilateral Indicator of "3" indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with either a modifier 50 or modifiers RT and LT, and a '2' in the units field, reimbursement is based on 100% of the Medicare allowed amount for each side less any applicable multiple procedure pricing rules. This query identifies claims with underpayments due to code being submitted with a quantity of "2" when performed bilaterally.	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	9/24/2019	Approved
Under specific requirements, Medicare covers FDG (fluorodeoxyglucose) Positron Emission Tomography (PET) scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be reviewed to determine if the utilization of PET scan for the diagnosis or treatment of dementing neurodegenerative diseases is medically necessary according to Medicare coverage indications.	0165 - Positron Emission Tomography for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	9/25/2019	Approved
Under specific requirements, Medicare covers FDG (fluorodeoxyglucose) Positron Emission Tomography (PET) scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be reviewed to determine if the utilization of PET scan for the diagnosis or treatment of dementing neurodegenerative diseases is medically necessary according to Medicare coverage indications.	0165 - Positron Emission Tomography for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	9/25/2019	Approved
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for a procedure is submitted and the surgeon's claim for the procedure is also submitted. The documentation for this procedure is the same as is the CPT/ HCPCS code billed. If, after complex review, there is a denial of the procedure code on the facility claim that is upheld, recover the physician claim for that same code automatically. Recouped procedure codes will result in an overpayment.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Catheterizations Billed as Separate Procedures	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	9/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for a procedure is submitted and the surgeon's claim for the procedure is also submitted. The documentation for this procedure is the same as is the CPT/ HCPCS code billed. If, after complex review, there is a denial of the procedure code on the facility claim that is upheld, recover the physician claim for that same code automatically. Recouped procedure codes will result in an overpayment.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Catheterizations Billed as Separate Procedures	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	9/27/2019	Approved
All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment. Unbundled services will be denied and result in an overpayment.	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states		Automated	11/27/2019	Approved
All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment. Unbundled services will be denied and result in an overpayment.	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states		Automated	11/27/2019	Approved
In current practice, invasive renal and peripheral angiography is mainly used to clarify inconclusive or contradictory findings of noninvasive studies; or used in conjunction with therapeutic procedures. Therefore, diagnostic (aka stand-alone) renal and peripheral angiography procedures will be denied without documentation of a prior, inconclusive non-invasive study that supports the medical necessity for invasive angiography. Additionally, renal and peripheral angiography services will be reviewed for application and observance of correct coding guidelines. Services that do not meet medical necessity and coding guidelines will be denied and result in an overpayment.	0170 - Renal and Peripheral Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	11/19/2019	Approved
In current practice, invasive renal and peripheral angiography is mainly used to clarify inconclusive or contradictory findings of noninvasive studies; or used in conjunction with therapeutic procedures. Therefore, diagnostic (aka stand-alone) renal and peripheral angiography procedures will be denied without documentation of a prior, inconclusive non-invasive study that supports the medical necessity for invasive angiography. Additionally, renal and peripheral angiography services will be reviewed for application and observance of correct coding guidelines. Services that do not meet medical necessity and coding guidelines will be denied and result in an overpayment.	0170 - Renal and Peripheral Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	11/19/2019	Approved
Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria.	0171 - Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	12/27/2019	Approved
Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria.	0171 - Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	12/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare pays for emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation or levels of service are contraindicated (i.e. would endanger the beneficiary, cause serious impairment to bodily functions or serious dysfunction of any body organ or part). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, and not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted or denied.	0175 - Emergency Ambulance Services – Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states		Complex	1/22/2020	Approved
Medicare pays for emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation or levels of service are contraindicated (i.e. would endanger the beneficiary, cause serious impairment to bodily functions or serious dysfunction of any body organ or part). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, and not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted or denied.	0175 - Emergency Ambulance Services – Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states		Complex	1/22/2020	Approved
Claims for HCPCS code G0402- Initial Preventative Physical Examination (IPPE), billed more than once in a lifetime, or after the initial 12 months or 12 months after the effective date of the beneficiary's first part B coverage period will be denied. Claims for HCPCS code G0438- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); initial, billed more than once in a lifetime will be denied. Claims for HCPCS code G0439- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); subsequent, billed more than once within 12 months of G0438 or G0439 will be denied.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	1/23/2020	Approved
Claims for HCPCS code G0402- Initial Preventative Physical Examination (IPPE), billed more than once in a lifetime, or after the initial 12 months or 12 months after the effective date of the beneficiary's first part B coverage period will be denied. Claims for HCPCS code G0438- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); initial, billed more than once in a lifetime will be denied. Claims for HCPCS code G0439- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); subsequent, billed more than once within 12 months of G0438 or G0439 will be denied.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	1/23/2020	Approved
The focus of this issue is to target claims where a potential overpayment exists when the definition of the procedure code includes imaging and the imaging was billed separately and paid.	0179 - Procedures that Include Imaging: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	3/4/2020	Approved
The focus of this issue is to target claims where a potential overpayment exists when the definition of the procedure code includes imaging and the imaging was billed separately and paid.	0179 - Procedures that Include Imaging: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	3/4/2020	Approved
CPT Codes with a Multiple Procedure Indicator of "6" are subject to a 25% reduction of the Technical Component (TC) when multiple procedures are billed on the same date of service, for the same patient, by the same physician, on the same claim. Claims incorrectly processed will be re-priced with the 25% reduction and the overpaid amount will be recovered. If the CPT code has a Multiple Procedure Indicator of '6' then 75% of the TC portion (Codes with an Indicator of '1') will be allowed and if the PC/TC Indicator is '3' (Technical component only codes) 75% of the Full Fee Schedule for that code will be allowed.	0182 - Reduction of Technical Component Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT Codes with a Multiple Procedure Indicator of "6" are subject to a 25% reduction of the Technical Component (TC) when multiple procedures are billed on the same date of service, for the same patient, by the same physician, on the same claim. Claims incorrectly processed will be re-priced with the 25% reduction and the overpaid amount will be recovered. If the CPT code has a Multiple Procedure Indicator of '6' then 75% of the TC portion (Codes with an Indicator of '1') will be allowed and if the PC/TC Indicator is '3' (Technical component only codes) 75% of the Full Fee Schedule for that code will be allowed.	0182 - Reduction of Technical Component Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	8/3/2020	Approved
Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training. Medical documentation for SCT will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted to the correct code or denied as applicable.	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states		Complex	8/3/2020	Approved
Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training. Medical documentation for SCT will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted to the correct code or denied as applicable.	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states		Complex	8/3/2020	Approved
For purposes of coverage under Medicare, Total Hip Arthroplasty (THA), also referred to as joint replacement, have proven to be an important medical advancement. Hip Arthroplasty surgery is most commonly performed for diseases which affect the function of the hip joint (ball (femoral head). Occasionally, there may be a need to redo a THA, often referred to as a revision total hip. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of a total hip replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) hip arthroplasties. The documentation will be reviewed to determine if a THA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto GBA, and Noridian.	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	8/3/2020	Approved
For purposes of coverage under Medicare, Total Hip Arthroplasty (THA), also referred to as joint replacement, have proven to be an important medical advancement. Hip Arthroplasty surgery is most commonly performed for diseases which affect the function of the hip joint (ball (femoral head). Occasionally, there may be a need to redo a THA, often referred to as a revision total hip. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of a total hip replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) hip arthroplasties. The documentation will be reviewed to determine if a THA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto GBA, and Noridian.	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
For purposes of coverage under Medicare, Total Knee Arthroplasty (TKA), also referred to as a joint replacement, has proven to be an important medical advancement. Knee Arthroplasty is most commonly performed for diseases which affect the function of the knee joint (the lower end of the femur, the upper end of the tibia and patella). Occasionally, there may be a need to redo a TKA, often referred to as a revision total knee. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of total knee replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) knee arthroplasties. The documentation will be reviewed to determine if a TKA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto, and Noridian.	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambultory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	8/3/2020	Approved
For purposes of coverage under Medicare, Total Knee Arthroplasty (TKA), also referred to as a joint replacement, has proven to be an important medical advancement. Knee Arthroplasty is most commonly performed for diseases which affect the function of the knee joint (the lower end of the femur, the upper end of the tibia and patella). Occasionally, there may be a need to redo a TKA, often referred to as a revision total knee. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of total knee replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) knee arthroplasties. The documentation will be reviewed to determine if a TKA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto, and Noridian.	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambultory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	8/3/2020	Approved
This review will determine if a duplex scan of the extracranial arteries was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	8/3/2020	Approved
This review will determine if a duplex scan of the extracranial arteries was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	8/3/2020	Approved
Medical documentation will be reviewed to determine if the use of nerve conduction studies meets Medicare coverage criteria and is reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	9/25/2020	Approved
Medical documentation will be reviewed to determine if the use of nerve conduction studies meets Medicare coverage criteria and is reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	9/25/2020	Approved
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record. When the documentation does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	9/24/2020	Approved
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record. When the documentation does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	9/24/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
A ventricular assist device (VAD) is surgically attached to one or both intact ventricles and is used to assist or augment the ability of a damaged or weakened native heart to pump blood. Improvement in the performance of the native heart may allow the device to be removed. The documentation will be reviewed to determine if a left ventricular assist device (LVAD) was placed for a Medicare-covered indication.	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	9/25/2020	Approved
A ventricular assist device (VAD) is surgically attached to one or both intact ventricles and is used to assist or augment the ability of a damaged or weakened native heart to pump blood. Improvement in the performance of the native heart may allow the device to be removed. The documentation will be reviewed to determine if a left ventricular assist device (LVAD) was placed for a Medicare-covered indication.	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	9/25/2020	Approved
Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the skin substitute applied to the patient, including any appropriate discarded waste. If the quantity of skin substitute applied to the wound used in the treatment plan of a patient is less than a multiple of the defined billing unit for the supported HCPCS code dosage descriptor, the provider must round to the next highest whole unit. The quantity used in the application of the skin substitute is billed on a separate line item than the allowable wastage. The wastage billing line (that corresponds to the discarded portion of a single use package) must be appended with the JW modifier. Documentation must support the service provided with the number of units billed as it correlates to the dosage increment specified in the HCPCS long descriptor. Units billed must also correspond to the actual quantity of skin substitute product applied to the wound during the treatment plan of the patient, including any appropriate discarded waste. The skin substitute product applied in the treatment of the patient must correlate with the appropriately rendered HCPCS code paid.	0193 - Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	10/1/2020	Approved
Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the skin substitute applied to the patient, including any appropriate discarded waste. If the quantity of skin substitute applied to the wound used in the treatment plan of a patient is less than a multiple of the defined billing unit for the supported HCPCS code dosage descriptor, the provider must round to the next highest whole unit. The quantity used in the application of the skin substitute is billed on a separate line item than the allowable wastage. The wastage billing line (that corresponds to the discarded portion of a single use package) must be appended with the JW modifier. Documentation must support the service provided with the number of units billed as it correlates to the dosage increment specified in the HCPCS long descriptor. Units billed must also correspond to the actual quantity of skin substitute product applied to the wound during the treatment plan of the patient, including any appropriate discarded waste. The skin substitute product applied in the treatment of the patient must correlate with the appropriately rendered HCPCS code paid.	0193 - Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	10/1/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Effective January 18, 2017, The Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED). Leadless pacemakers are non-covered when furnished outside of a CMS approved CED study. The documentation will be reviewed to determine if the use of a leadless pacemaker meets Medicare coverage guidelines and applicable coding guidelines.	0194 - Leadless Pacemakers: Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	10/1/2020	Approved
The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Effective January 18, 2017, The Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED). Leadless pacemakers are non-covered when furnished outside of a CMS approved CED study. The documentation will be reviewed to determine if the use of a leadless pacemaker meets Medicare coverage guidelines and applicable coding guidelines.	0194 - Leadless Pacemakers: Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	10/1/2020	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	10/23/2020	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	10/23/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider whether the initial placement of Deep Brain Stimulation is reasonable and necessary for the treatment of Parkinson’s disease and Essential Tremor, under certain conditions.	0196 - Deep Brain Stimulation-Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	11/18/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider whether the initial placement of Deep Brain Stimulation is reasonable and necessary for the treatment of Parkinson's disease and Essential Tremor, under certain conditions.	0196 - Deep Brain Stimulation- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	11/18/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider DBS to be reasonable and necessary for the treatment of Parkinson's disease under certain conditions.	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states		Complex	11/18/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider DBS to be reasonable and necessary for the treatment of Parkinson's disease under certain conditions.	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states		Complex	11/18/2020	Approved
A distal claviculectomy requires approximately 1 cm (or 8-10 mm) of bone to be removed to report 23120 Claviculectomy; partial or 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure). Documentation will be reviewed to determine that a partial claviculectomy was performed. Services that are not medically reasonable and necessary and/or do not support the procedure code billed may result in an overpayment or underpayment.	0199 - Distal Claviculectomy: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	11/21/2020	Approved
A distal claviculectomy requires approximately 1 cm (or 8-10 mm) of bone to be removed to report 23120 Claviculectomy; partial or 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure). Documentation will be reviewed to determine that a partial claviculectomy was performed. Services that are not medically reasonable and necessary and/or do not support the procedure code billed may result in an overpayment or underpayment.	0199 - Distal Claviculectomy: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	11/21/2020	Approved
This purpose of this review is to ensure Medicare coverage criteria for air ambulance transport have been met. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). You may furnish air Medicare ambulance transportation to a beneficiary when all of these criteria are met: • The transportation is medically necessary • Any other means of transportation is contraindicated • A Medicare beneficiary is transported to an acute care hospital This complex review will be examining rotatory wing (helicopter) aircraft claims to determine if air ambulance transport was reasonable and medically necessary as well as whether or not documentation requirements have been met.	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states		Complex	2/4/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This purpose of this review is to ensure Medicare coverage criteria for air ambulance transport have been met. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). You may furnish air Medicare ambulance transportation to a beneficiary when all of these criteria are met: • The transportation is medically necessary • Any other means of transportation is contraindicated • A Medicare beneficiary is transported to an acute care hospital This complex review will be examining rotatory wing (helicopter) aircraft claims to determine if air ambulance transport was reasonable and medically necessary as well as whether or not documentation requirements have been met.	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states		Complex	2/4/2021	Approved
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay. A denial of services will result in an overpayment.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 – all applicable states		Automated	2/4/2021	Approved
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay. A denial of services will result in an overpayment.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 – all applicable states		Automated	2/4/2021	Approved
Payment for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures is determined based on the base unit of the anesthesia procedure with the highest base unit value, and time units based on the actual anesthesia time of the multiple procedures. Incorrectly paid codes will be re-priced based on the correct conversion factor calculations and recovered as overpayments.	0203 - Anesthesia Associated with Multiple Surgeries: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states		Automated	3/3/2021	Approved
Payment for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures is determined based on the base unit of the anesthesia procedure with the highest base unit value, and time units based on the actual anesthesia time of the multiple procedures. Incorrectly paid codes will be re-priced based on the correct conversion factor calculations and recovered as overpayments.	0203 - Anesthesia Associated with Multiple Surgeries: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states		Automated	3/3/2021	Approved
Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures	0204 - Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states		Complex	3/11/2021	Approved
Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures	0204 - Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states		Complex	3/11/2021	Approved
Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	3 years prior to ADR Letter date	2 – all applicable states		Complex	5/29/2021	Approved
Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	3 years prior to ADR Letter date	3 – all applicable states		Complex	5/29/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered reasonable and necessary when clinical management of the patient would differ depending on the staging of the cancer identified, and in clinical situations in which the stage of the cancer remains in doubt after completing a standard diagnostic workup or it is expected that conventional imaging study information is insufficient for clinical management of the patient. Medical records will be reviewed to determine if the utilization of FDG PET studies for initial anti-tumor treatment strategy are medically necessary according to Medicare coverage indications.	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states		Complex	5/29/2021	Approved
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered reasonable and necessary when clinical management of the patient would differ depending on the staging of the cancer identified, and in clinical situations in which the stage of the cancer remains in doubt after completing a standard diagnostic workup or it is expected that conventional imaging study information is insufficient for clinical management of the patient. Medical records will be reviewed to determine if the utilization of FDG PET studies for initial anti-tumor treatment strategy are medically necessary according to Medicare coverage indications.	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states		Complex	5/29/2021	Approved
Dorsal Column (Spinal cord) stimulation involves surgical implantation of neurostimulator electrodes within the dura mater (endodural) or percutaneous insertion of electrodes in the epidural space. The implantation consists of two stages: the first stage contains an implantation of neurostimulator electrode(s) and a connection of an external neurostimulator. In some cases, temporary electrodes are used. It is a short trial to assess the patient's suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. The second stage involves subcutaneous insertion of a permanent neurostimulator with connection of the implanted electrode(s). Spinal cord neurostimulators (SCS) may be covered as therapies for the relief of chronic intractable pain, and medical records will be reviewed to determine if the implantation of SCS meets Medicare coverage criteria and documentation requirements.	0207 - Spinal Cord Neurostimulation: Medical Necessity and Documentation Requirements	Hospital Outpatient; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	2 – all applicable states		Complex	5/29/2021	Approved
Dorsal Column (Spinal cord) stimulation involves surgical implantation of neurostimulator electrodes within the dura mater (endodural) or percutaneous insertion of electrodes in the epidural space. The implantation consists of two stages: the first stage contains an implantation of neurostimulator electrode(s) and a connection of an external neurostimulator. In some cases, temporary electrodes are used. It is a short trial to assess the patient's suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. The second stage involves subcutaneous insertion of a permanent neurostimulator with connection of the implanted electrode(s). Spinal cord neurostimulators (SCS) may be covered as therapies for the relief of chronic intractable pain, and medical records will be reviewed to determine if the implantation of SCS meets Medicare coverage criteria and documentation requirements.	0207 - Spinal Cord Neurostimulation: Medical Necessity and Documentation Requirements	Hospital Outpatient; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	3 – all applicable states		Complex	5/29/2021	Approved