Cotiviti Approved Issues List as of March 21, 2023

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Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	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. Review of Length of Stay and 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 §405.929- 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 Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §20- Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs) 8.Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §§20.1.2.4. B & C, 40.2.4 9.Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6 10.Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review, §6.5.4 – Review of Procedures Affecting the DRG 11.Inpatient Prospective Payment System (IPPS) Final Rule and Correcting Amendment Tables: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page 12.ICD-10 Clinical Modification (ICD-10-CM) and ICD-10- Procedural Coding System (PCS) (ICD-10-PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums	Complex	1/23/2017	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	Complex	2/12/2017	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 Hospital, Outpatient Hospital, Ambulatory Surgery Center (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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	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	Complex	1/23/2017	Approved
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	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	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	Automated	1/29/2017	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	0022 - Inpatient Psychiatric Admission 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	Automated	2/27/2017	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	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	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 (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	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	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 §405.929- Post-Payment Review; 4. 2 CFR §405.930- Failure to	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	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 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	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	Automated	3/23/2017	Approved
A new patient is one who has not received any professional services, [e.g., E/M service or other face-to-face service (e.g., surgical procedure)] from the physician or physician group practice (same physician specialty) within the previous 3 years. The subsequently billed new patient visit will be denied if another E/M procedure	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.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	Automated	3/23/2017	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	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	Automated	8/8/2017	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	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	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	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	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,	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	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	Automated	8/7/2017	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 may not exceed (1) in the units billed column per date of service.	0060 - Untimed Therapy: Excessive Units	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Rehabilitation Facility (ORF), Comprehensive Outpatient Rehabilitation Facility (CORF)	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	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	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"	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 (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	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 (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	Automated	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 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 1814(a)(2)(A) and (4)- Conditions of and Limitations on Payment for Services 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1815(a)- Payment to Providers of Services	Complex	9/8/2017	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	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42	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	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, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits	Complex	10/4/2018	Approved
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 in Single-Dose Vials: 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	Complex	12/21/2017	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) 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	Automated	1/9/2018	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 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions,	Automated	3/13/2018	Approved
Hospital outpatient observation care (initial, subsequent and/or discharge management) rendered on the same date as a hospital inpatient admission by the same physician is not separately payable. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission	0086 - Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission: 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	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	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	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	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,	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	Issue Type	Date Approved	Approval Status
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 §1861(hh)- Clinical Social Worker,	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	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	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	0091- Duplicate Claims: Professional Services	Part B 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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional	Automated	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcutaneous placement of a device.	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	Complex	5/8/2018	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	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: 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 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	Complex	5/14/2018	Approved
Facet joint are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. Intraarticular blocks may provide	0095 - Facet Joint Interventions: Medical Necessity and Documentation Requirements	Inpatient Hospital (Part B), Outpatient Hospital, Outpatient Surgery	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	Complex	2/1/2023	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.	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	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	Automated	6/25/2018	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	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	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	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	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	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	0104 - Add-on Code 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	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	Automated	7/24/2018	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	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	6 months 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,	Automated	9/11/2018	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	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	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusion 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	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.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital (Medicare Part B only), Outpatient Hospital, Skilled Nursing Facility - Inpatient (Medicare Part B only)	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	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	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	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,	Automated	11/7/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. Providers cannot bill for services that are rendered. Physician claims billed with a home-related place of service that overlaps an inpatient hospital stay will be	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	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	Automated	10/17/2018	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	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	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	Automated	10/9/2018	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	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	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	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	0124 - Part B Therapies during Inpatient: Unbundling	Physical Therapist, Occupational Therapist, Speech Language Therapist	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	Automated	11/30/2018	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	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	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,	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	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	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	Complex	1/30/2019	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	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- ExclusionsSocial 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	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	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	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	Complex	2/5/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	Issue Type	Date Approved	Approval Status
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	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital	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	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	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	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	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	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	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	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 1834 - Special Payment Rules for Particular Items and Services; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section	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	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital and 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	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	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC), Skilled Nursing Facility (SNF)	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	Automated	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. The less extensive CT scan code(s) will be recovered as an overpayment.	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	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	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. The less extensive MRI procedure code(s) will be recovered as an overpayment(s).	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	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	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); exclude non-physician practitioner codes 50 (NP) and 97 (PA)	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	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	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	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	Complex	4/30/2019	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 MPFS payment meet Medicare coverage criteria and applicable coding guidelines.	0151 - Physician/Non-Physician Practitioner Coding Validation	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgical Center (ASC)	3 years prior to ADR 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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42	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	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 as well as state/date exclusions: 1. Exclude NJ, PA, SC, DE, DC, MD, NC, WV, and VA	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	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	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	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,	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	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Hospital, Outpatient Rehabilitation 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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	7/15/2019	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); 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	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 Infusions: Incorrect Coding and Documentation Requirements	Outpatient Hospital	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	Complex	11/18/2019	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	0164 - Bilateral Indicator '3': 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	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	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	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	Complex	9/25/2019	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 and including the date of the beneficiary's admission are deemed to be inpatient	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	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	Automated	11/27/2019	Approved
Documentation will be reviewed to determine if diagnostic (aka stand-alone) renal and peripheral angiography procedures meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	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	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	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	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	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	Complex	12/27/2019	Approved
Claims for HCPCS code G0402- Initial Preventative Physical Examination (IPPE), may not be billed more than 12 months after the effective date of the beneficiary's first part B coverage, or more than once in a lifetime.	0176 - Annual Wellness Visits: Incorrect Coding	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 1861 (s)(2)(W)- an initial preventive	Complex	1/23/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	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	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	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	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 appropriate when a beneficiary's condition requires	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	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	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	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, 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	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	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	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	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	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	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	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	Complex	9/25/2020	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.	0190 - Skilled Nursing Facility with Patient-Driven Payment Model: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	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	Complex	7/20/2022	Approved
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	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 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	Complex	9/24/2020	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	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	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	Complex	9/25/2020	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	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	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	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	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	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	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	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	11/18/2020	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	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	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	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	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	Automated	2/4/2021	Approved
Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. VNS is not considered medically necessary for all other types of seizure disorders which are	0204 - Vagus Nerve Stimulation: 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 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	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	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	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	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	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient, 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 Benefit	Complex	5/29/2021	Approved
Hypoglossal nerve stimulation (HNS) is reasonable and necessary for the treatment of moderate to severe obstructive sleep apnea (OSA) when coverage criteria are met. Documentation will be reviewed to determine if HNS meets Medicare coverage criteria, applicable coding guidelines, and/or are medically	0210 - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	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, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits	Complex	6/29/2022	Approved
Per the 2019 and 2020 AMA CPT manuals, do not report CPT codes 99358 and/or 99359 during the same calendar month as CPT codes 99484, 99487, 99489, 99490, 99491, 99492, 99493, 99494.	0211 - Prolonged Service Codes: Unbundling	Professional Services (Physician/Non-Physician Practitioners)	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	Automated	1/26/2023	Approved
Documentation will be reviewed to determine whether Transurethral waterjet ablation services met Medicare coverage criteria and were reasonable and necessary.	0214 - Transurethral Waterjet Ablation of the Prostate for Benign Prostatic Hyperplasia (BPH) with Lower Urinary Tract Symptoms (LUTS): Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), and 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 §405.929- Post-Payment Review 4.42 CFR §405.930- Failure to Respond to Additional Documentation Request	Complex	4/26/2023	Approved
Documentation will be reviewed to determine if CPT code 15734 warranted separate reimbursement given that a flap is considered inclusive to breast reconstruction (19357-19364, 19367-19369) or breast prosthesis (19340, 19342). Documentation will be reviewed to support a that the flap (15734) was performed at a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not	0217 - Muscle Flap with Breast Reconstruction or Breast Prosthesis Insertion: Unbundling	Physician/Non-physician Practitioner (NPP)	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 §405.929- 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)-	Complex	6/6/2023	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	1967	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine whether minimally invasive surgical fusion of the sacroiliac joint met Medicare coverage criteria and was reasonable and necessary.	0219 - Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac Joint: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)	Claims having a "paid claim date" which is less than 3 years prior to the ADR letter date. JJ and JM are limited to DOS on/after 7/17/2022.	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	Complex	6/6/2023	Approved