Cotiviti Approved Issues List as of June 11, 2021

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. 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 Coding Manual; 9) ICD-10 CM Addendums; 10) ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 11) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 12) 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. 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 Coding Manual; 9) ICD-10 CM Addendums; 10) ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 11) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 12) 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 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 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; 7) 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; 8) 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; 9) CGS LCD L33954- Cataract Extraction; Effective 10/01/2015; Revised 09/19/2019; 10) NGS LCD L33558- Cataract Extraction; Effective 10/1/2015; Revised 01/01/2020; 11) Noridian LCD L34203- Cataract Surgery in Adults; Effective 10/01/2015; Revised 10/17/2017; Revision effective for DOS performed on or after 10/01/2019; 12) Noridian LCD L37027- Cataract Surgery in Adults; Effective 10/10/2017; Revised 10/01/2019; Revision effective for DOS performed on or after 10/01/2019; 13) Palmetto LCD L34413- Cataract Surgery; Effective 10/01/2015; Revised 06/13/2019; 14) Palmetto LCA A53047- Complex Cataract Surgery: Appropriate Use and Documentation; Effective 10/01/2015; Revised 02/26/2018; 15) Novitas LCD L35091- Cataract Extraction (including Complex Cataract Surgery), Effective 10/01/2015; Revised 08/10/2019; Revision effective for DOS performed on or after 11/07/2019; 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 09/19/2019	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 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 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; 7) 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; 8) 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; 9) CGS LCD L33954- Cataract Extraction; Effective 10/01/2015; Revised 09/19/2019; 10) NGS LCD L33558- Cataract Extraction; Effective 10/1/2015; Revised 01/01/2020; 11) Noridian LCD L34203- Cataract Surgery in Adults; Effective 10/01/2015; Revised 10/17/2017; Revision effective for DOS performed on or after 10/01/2019; 12) Noridian LCD L37027- Cataract Surgery in Adults; Effective 10/10/2017; Revised 10/01/2019; Revision effective for DOS performed on or after 10/01/2019; 13) Palmetto LCD L34413- Cataract Surgery; Effective 10/01/2015; Revised 06/13/2019; 14) Palmetto LCA A53047- Complex Cataract Surgery: Appropriate Use and Documentation; Effective 10/01/2015; Revised 02/26/2018; 15) Novitas LCD L35091- Cataract Extraction (including Complex Cataract Surgery), Effective 10/01/2015; Revised 08/10/2019; Revision effective for DOS performed on or after 11/07/2019; 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 09/19/2019	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 04/16/2019; 8) Novitas Solutions, Inc., LCD L34707- Sacral Nerve Stimulation, Effective 07/24/2014; Retired 09/30/2015; 9) Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 9/14/2017; 10) Noridian Healthcare Solutions, LLC, LCA A51767 Article for Sacral Nerve Stimulation for Urinary and Fecal Incontinence R3, Effective 04/20/2012; Retired 9/30/2015; 11) Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 10/01/2016; 12) Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 10/01/2016; 13) CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; 14) 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 04/16/2019; 8) Novitas Solutions, Inc., LCD L34707- Sacral Nerve Stimulation, Effective 07/24/2014; Retired 09/30/2015; 9) Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 9/14/2017; 10) Noridian Healthcare Solutions, LLC, LCA A51767 Article for Sacral Nerve Stimulation for Urinary and Fecal Incontinence R3, Effective 04/20/2012; Retired 9/30/2015; 11) Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 10/01/2016; 12) Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 10/01/2016; 13) CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; 14) 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 - SNF Review: 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 Requirements; 6) 42 Code of Federal Regulations 424.20 Requirements for posthospital SNF care; 7) 42 Code of Federal Regulations 483.20 Resident assessment; 8) 42 Code of Federal Regulations 411.15(k)(1); 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) 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; 11) 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, §6.1.4- Bill Review Process, §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 12) 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; 13) 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 - SNF Review: 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 Requirements; 6) 42 Code of Federal Regulations 424.20 Requirements for posthospital SNF care; 7) 42 Code of Federal Regulations 483.20 Resident assessment; 8) 42 Code of Federal Regulations 411.15(k)(1); 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) 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; 11) 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, §6.1.4- Bill Review Process, §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 12) 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; 13) 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.	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) 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 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; 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 10/10/2019; 10) Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/17/2019; 11) NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/1/2015; Revision 10/1/2019; 12) Noridian LCA A53026- Bariatric Surgery Coverage; Effective 10/1/2015; Revised 10/01/2018; 13) Noridian LCA A53028- Bariatric Surgery Coverage; Effective 10/1/2015; Revised 10/01/2018; 14) Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2019; 15) WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/1/2016; Revised:11/01/2019; 16) Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/10/2019; 17) First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; 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.	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) 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 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; 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 10/10/2019; 10) Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/17/2019; 11) NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/1/2015; Revision 10/1/2019; 12) Noridian LCA A53026- Bariatric Surgery Coverage; Effective 10/1/2015; Revised 10/01/2018; 13) Noridian LCA A53028- Bariatric Surgery Coverage; Effective 10/1/2015; Revised 10/01/2018; 14) Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2019; 15) WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/1/2016; Revised:11/01/2019; 16) Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/10/2019; 17) First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; 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) 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 (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, Section 220.6.1- PET for Perfusion of the Heart, Effective 4/03/2009; 7) Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, Section 220.6.8- FDG PET for Myocardial Viability, Effective 1/28/2005; 8) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 50- Nuclear Medicine; 9) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 60- Positron Emission Tomography (PET) Scans- General Information; 10) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 60.9- Coverage of PET Scans for Myocardial Viability; 11) Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 60.11- Coverage of PET Scans for Perfusion of the Heart Using Ammonia N-13; 12) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, Section 13.5.1- Reasonable and Necessary Provisions in LCDs; 13) First Coast LCD L36209- Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET, Effective 10/01/2015; Revised 9/13/2018; 14) First Coast LCD L35933- Cardiology— non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET, Effective 6/29/2015; Retired 9/30/2015; 15) First Coast LCD L29455- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 3/02/2009; Retired 6/29/2015; 16) First Coast LCD L28954- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 3/02/2009; Retired 6/29/201517) First Coast LCD L28933- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 2/16/2009; Retired 6/29/2015; 18) First Coast LCD L29231- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 2/02/2009; Retired 6/29/2015; 19) Annual American Medical Association: CPT Manual, Coding Guidelines; 20) Annual ICD-9-CM Manual, Coding Guidelines; 21) Annual HCPCS Manual, Coding Guidelines	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; 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; 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 (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) Claims Processing Manual Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 7) 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) 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 (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) Claims Processing Manual Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 7) 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) Claims Processing Manual Chapter 3- Inpatient Hospital Billing, §190.10.1- General Rules	Automated	2/27/2017	Approved
To identify claims where modifier -59 has been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together.	0027 - Improper payments for 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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 2) Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; 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 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 (CMS Publication 100-04), Chapter 23 (Fee Scheduled Administration and Coding Requirements), §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifier "-59"; 7) NCCI Manuals, 2015, 2016, 2017, 2018, and 2019 Chapter 1 – General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 8) NCCI Manuals, 2015, 2016, 2017, 2018, and 2019 Chapter 11 – Medicine & E/M CPT Codes 9000-9999 for National Correct Coding Initiative Policy Manual for Medicare 9) CPT Manual	Complex	4/3/2017	Approved
To identify claims where modifier -59 has been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together.	0027 - Improper payments for 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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 2) Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; 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 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 (CMS Publication 100-04), Chapter 23 (Fee Scheduled Administration and Coding Requirements), §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifier "-59"; 7) NCCI Manuals, 2015, 2016, 2017, 2018, and 2019 Chapter 1 – General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 8) NCCI Manuals, 2015, 2016, 2017, 2018, and 2019 Chapter 11 – Medicine & E/M CPT Codes 9000-9999 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
Claims for trastuzumab (Herceptin) multi-dose vials billed with medication wastage will be denied based on Medicare guidelines outlined by CMS Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40 “Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological."	0036 - Trastuzumab (Herceptin) Multi-Dose Vial: Incorrect Wastage	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital	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, §1833(e) Payment of Benefits; 2) 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; 3) 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4) 42 Code of Federal Regulations §405.980 (b)(c)- 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 17 (Drugs and Biologicals), §40- Discarded Drugs and Biologicals; 7) Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 8) Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Error and Taking Corrective Actions), §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests	Complex	2/27/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for trastuzumab (Herceptin) multi-dose vials billed with medication wastage will be denied based on Medicare guidelines outlined by CMS Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40 "Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological."	0036 - Trastuzumab (Herceptin) Multi-Dose Vial: Incorrect Wastage	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital	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, §1833(e) Payment of Benefits; 2) 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; 3) 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4) 42 Code of Federal Regulations §405.980 (b)(c)- 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 17 (Drugs and Biologicals), §40- Discarded Drugs and Biologicals; 7) Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 8) Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Error and Taking Corrective Actions), §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests	Complex	2/27/2017	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 2019	Automated	3/23/2017	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	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 2019	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.	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 Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.D- Visits to Patients in Swing Beds	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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 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
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.	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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting.	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 Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, Section 30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV], Effective 1/27/2014; 7. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, Section 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code, Effective 1/1/2016; 8. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, Section 30.6.9 - Payment for Inpatient Hospital Visits – General, Effective 1/1/2011; 9. AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	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	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/Non-physician Practitioners, Section 30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV], Effective 1/27/2014; 7. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, Section 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code, Effective 1/1/2016; 8. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, Section 30.6.9 - Payment for Inpatient Hospital Visits – General, Effective 1/1/2011; 9. 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 [eg, diabetic retinopathy], photocoagulation), billed more frequently than once per eye within the global surgery period will be denied, based on CGS LCDs L34064 and L31888 (Retired) and NGS LCDs L33628 and L28497 (Retired), as applicable.	0047 - Panretinal (Scatter) Laser Photocoagulation - Excess 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) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Title XVIII, §1833(e) of the Social Security Act- 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, CMS Publication 100-08, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), §§3.5.1 and 3.6; 7) Medicare Program Integrity Manual, CMS Publication 100-08, Chapter 3 (No Response or Insufficient Response to Additional Documentation Requests), §§3.2.3.8; 8) CGS Administrators, Local Coverage Determination (LCD) L31888: Effective 4/30/2011; Revision 5/17/2015; Retired 9/30/2015; 9) CGS Administrators, Local Coverage Determination (LCD) L34064: Effective 10/01/2015; Revision 10/01/2016; 10) CGS Administrators, Local Coverage Article A50840: Effective 4/30/2011; Revision 5/17/2015; Retired 9/30/2015; 11) NGS, Local Coverage Determination (LCD) L28497: Effective 1/01/2009; Revision 9/01/2014; Retired 9/30/2015; 12) NGS, Local Coverage Determination (LCD) L33628: Effective 10/01/2015; Revision 1/01/2018; 13) NGS, Local Coverage Article A48012: Effective 1/01/2009; Revision 9/01/2014; Retired 9/30/2015; 14) NGS, Local Coverage Article A52822: Effective 10/01/2015; Revision 1/01/2016; Retired 5/01/2016	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Algorithm identifies all paid Ambulance Claims billed with any HCPCS codes listed from the table “Ambulance HCPCS Codes” and modifier NN on the same line, for SNF claims.	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 from the table “Ambulance HCPCS Codes” and modifier NN on the same line, for SNF claims.	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
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

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	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.	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 Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; 6) Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 7) Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 8) 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); 9) Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 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) Facility Outpatient Hospital Services and Practitioner Services MUE Tables	Automated	4/26/2017	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.	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 Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; 6) Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 7) Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 8) 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); 9) Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 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) Facility Outpatient Hospital Services and Practitioner Services MUE Tables	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 Claims Processing Manual, Chapter 3- Inpatient Hospital Billing §10.5- Hospital Inpatient Bundling; 6) 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 Claims Processing Manual, Chapter 3- Inpatient Hospital Billing §10.5- Hospital Inpatient Bundling; 6) Medicare Claims Processing Manual, Chapter 15- Ambulance §30.1.4 CWF Editing of Ambulance Claims for Inpatients	Automated	6/20/2017	Approved
When evaluation and management (E/M) services are provided to patients in a Skilled Nursing Facility (SNF), CPT codes (99306, 99309, 99310) should be reported. It is inappropriate to report hospital inpatient care codes (99223, 99232, 99233) for SNF E/M services.	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 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 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7) AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved
When evaluation and management (E/M) services are provided to patients in a Skilled Nursing Facility (SNF), CPT codes (99306, 99309, 99310) should be reported. It is inappropriate to report hospital inpatient care codes (99223, 99232, 99233) for SNF E/M services.	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 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 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7) AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved
Shoulder arthroscopy procedures include a limited debridement (e.g., 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.	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, 2019	Complex	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Shoulder arthroscopy procedures include a limited debridement (e.g., 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.	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, 2019	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) American Medical Association (AMA), Current Procedure Terminology 2014 to current; 7) Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services, Sections 220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services Under Medical Insurance, and 230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 8) Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), §§10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) (Revised March 9, 2018)	Automated	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	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) American Medical Association (AMA), Current Procedure Terminology 2014 to current; 7) Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services, Sections 220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services Under Medical Insurance, and 230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 8) Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), §§10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) (Revised March 9, 2018)	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.	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), §3.5.1 Re-opening Claims, §3.6 Determinations Made During Review; 9) American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 10) Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Revised 11/21/2019	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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), §3.5.1 Re-opening Claims, §3.6 Determinations Made During Review; 9) American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 10) Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Revised 11/21/2019	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.	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) Change Request 5675; 8) 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.	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) Change Request 5675; 8) Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, § 10.7 – Type of Service	Automated	9/8/2017	Approved
CPT Code 99291 is used to report the first 30 - 74 minutes of Critical Care on a given calendar date of service. It should only be used once per calendar date per beneficiary by the same physician or physician group of the same specialty.	0063 - Critical Care: 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, 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- Critical Care Visits and Neonatal Intensive Care (Codes 99291 and 99292), Section (F)- Hours and Days of Critical Care that may be Billed, Section (G)- Counting of Units of Critical Care Services, and Section (I)- Critical Care Services Provided by Physicians in Group Practice(s)	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT Code 99291 is used to report the first 30 - 74 minutes of Critical Care on a given calendar date of service. It should only be used once per calendar date per beneficiary by the same physician or physician group of the same specialty.	0063 - Critical Care: 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, 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- Critical Care Visits and Neonatal Intensive Care (Codes 99291 and 99292), Section (F)- Hours and Days of Critical Care that may be Billed, Section (G)- Counting of Units of Critical Care Services, and Section (I)- Critical Care Services Provided by Physicians in Group Practice(s)	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) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Title XVIII, §1833(e) of the Social Security Act- 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 Claims Processing Manual, CMS Publication 100-04, Chapter 1, §120.2(A)- Submission of Institutional Claims	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) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 2) Title XVIII, §1833(e) of the Social Security Act- 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 Claims Processing Manual, CMS Publication 100-04, Chapter 1, §120.2(A)- Submission of Institutional Claims	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	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) Fourth Edition, Text Revision of the American Psychiatric Associations Diagnostic and Statistical Manual; 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
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary	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) Fourth Edition, Text Revision of the American Psychiatric Associations Diagnostic and Statistical Manual; 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
Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician or physician group with the same specialty to the same patient.	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, § 30.6.12 – 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)	Automated	10/5/2017	Approved
Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician or physician group with the same specialty to the same patient.	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, § 30.6.12 – 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)	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	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
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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	0073 - Inpatient Rehabilitation Facility Stays: 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	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.	0073 - Inpatient Rehabilitation Facility Stays: 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	Complex	10/4/2018	Approved
Drugs and Biologicals should be billed in multiples of the dosage specified in the CPT/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. If the drug dose used in the care of a patient is less than a multiple of the CPT/HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, pharmacist, certified pharmacy technician, or certified coder 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; 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
Drugs and Biologicals should be billed in multiples of the dosage specified in the CPT/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. If the drug dose used in the care of a patient is less than a multiple of the CPT/HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, pharmacist, certified pharmacy technician, or certified coder 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; 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
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; 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; 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

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	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- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 05/01/2016; 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- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/1/2016; 10) NGS Local Coverage Article A54909- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016; Revised 05/01/2016; 11) Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016; Revised 9/5/2018; 12) Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016, Revised 9/5/2018; 13) Novitas Local Coverage Article A54982- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/1/2016; Revised 11/8/2018; 14) Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 10/01/2019; 15) WPS Local Coverage Article A54958- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/15/2016; Revised 4/01/2018; 16) Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018	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	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- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 05/01/2016; 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- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/1/2016; 10) NGS Local Coverage Article A54909- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016; Revised 05/01/2016; 11) Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016; Revised 9/5/2018; 12) Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 4/15/2016, Revised 9/5/2018; 13) Novitas Local Coverage Article A54982- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/1/2016; Revised 11/8/2018; 14) Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 10/01/2019; 15) WPS Local Coverage Article A54958- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Coding and Billing; Effective 5/15/2016; Revised 4/01/2018; 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) Title XVIII of the Social Security Act: Section 1833€; 2) Title XVIII of the Social Security Act: Section 1862(a)(1)(A); 3) National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	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, 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) Title XVIII of the Social Security Act: Section 1833€; 2) Title XVIII of the Social Security Act: Section 1862(a)(1)(A); 3) National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	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	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.	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) 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 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.	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) 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 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 8) Current Procedural Terminology Coding Book	Automated	3/13/2018	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 and Management Services Billed Same Day as 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) 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 §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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 8) 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
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 and Management Services Billed Same Day as 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) 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 §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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 8) 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 §405.980- 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 11- End Stage Renal Disease, §20.2- Laboratory Services; 7) Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 8) ESRD PPS Consolidated Billing (files for 2014 – 2019) 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 §405.980- 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 11- End Stage Renal Disease, §20.2- Laboratory Services; 7) Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 8) ESRD PPS Consolidated Billing (files for 2014 – 2019) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	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 identified in Appendix D are not payable if there is no approved 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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 7) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 8) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 9) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 10) Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 15 (Covered Medical and Other Health Services), §260- Ambulatory Surgical Center Services; 11) Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 14 (Ambulatory Surgery Centers), §40- Payment for Ambulatory Surgery	Automated	3/14/2018	Approved
Covered ancillary items and services identified in Appendix D are not payable if there is no approved 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) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 7) 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 8) 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 9) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 10) Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 15 (Covered Medical and Other Health Services), §260- Ambulatory Surgical Center Services; 11) Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 14 (Ambulatory Surgery Centers), §40- Payment for Ambulatory Surgery	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 §1861(hh)- Clinical Social Worker, (hh)(2)- Clinical Social Worker Services; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 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) 42 CFR §409.10(a)(4)- Included Services- Medical Social Services; 7) 42 CFR §410.73- Clinical Social Worker Services; 8) 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 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) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 11) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 12) WPS, Local Coverage Article A54829- Clinical Social Worker Services; Effective 2/01/2016; Revised 3/01/2018	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	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 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 §405.986- Good Cause for Reopening; 6) 42 CFR §409.10(a)(4)- Included Services- Medical Social Services; 7) 42 CFR §410.73- Clinical Social Worker Services; 8) 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 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) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 11) Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 12) WPS, Local Coverage Article A54829- Clinical Social Worker Services; Effective 2/01/2016; Revised 3/01/2018	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 §405.980- 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: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 7) Medicare Claims Processing Manual 100-04; Chapter 23; File Layout	Automated	4/4/2018	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 §405.980- 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: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 7) Medicare Claims Processing Manual 100-04; Chapter 23; File Layout	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.	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 (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 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, §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
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.	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 (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 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, §10.5- Place of Service Codes (POS) and Definitions	Automated	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: 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) 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: 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) 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 as published in the CMS National Coverage Determinations (NCD) Manual, Publication 100-03, Section 20.4 and CMS IOM 100-04, Ch. 32 §§270,270.1,270.2.	0093 - Implantable Automatic Defibrillators: 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 National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1- Sections 10- 80.12, Section 20.4- Implantable Automatic Defibrillators (ICDs), Effective 2/15/2018; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 9) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 10) First Coast Local Coverage Article A56341 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 11) Novitas Local Coverage Article A56355 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 12) Palmetto Local Coverage Article: A56343 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 13) WPS Local Coverage Article A56391 – Implantable Automatic Defibrillators. Effective 5/13/2019; Revised 10/31/2019; 14) NGS Local Coverage Article A56326 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019	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 as published in the CMS National Coverage Determinations (NCD) Manual, Publication 100-03, Section 20.4 and CMS IOM 100-04, Ch. 32 §§270,270.1,270.2.	0093 - Implantable Automatic Defibrillators: 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 National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1- Sections 10- 80.12, Section 20.4- Implantable Automatic Defibrillators (ICDs), Effective 2/15/2018; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 9) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 10) First Coast Local Coverage Article A56341 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 11) Novitas Local Coverage Article A56355 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 12) Palmetto Local Coverage Article: A56343 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019; 13) WPS Local Coverage Article A56391 – Implantable Automatic Defibrillators. Effective 5/13/2019; Revised 10/31/2019; 14) NGS Local Coverage Article A56326 – Implantable Automatic Defibrillators. Effective 3/26/2019; Revised 10/01/2019	Complex	5/14/2018	Approved
Certain services when performed on the day a physician bills for critical care 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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Certain services when performed on the day a physician bills for critical care 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 appendix D 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: Outpatient Facility - Not Separately Payable Services	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	Automated	6/25/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services listed in appendix D 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: Outpatient Facility - Not Separately Payable Services	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	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 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: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013) 10) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html	Automated	6/20/2018	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	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: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; 8) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013) 10) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html	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	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 §414- Payment for Part B Medical and Other Health Services; 4) 42 CFR §419- Prospective Payment System for Hospital Outpatient Department 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) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 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 Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS) §§10.1- 10.5, 20, 40-61, 100, 120, 150-240, 270, and 300; 10) American Medical Association (AMA), Current Procedure Terminology, Coding and Payment, APC Payment Book, APC Grouping Logic: Comprehensive APCs (SI=J1) , APCs for Hospital Part B services paid through a comprehensive APC (SI = J1), Procedure or Service, Not Discounted When Multiple (SI=S), Procedure or Service, Multiple Reduction Applies (SI = T), and Nonpass-Through Drugs and Biologicals (SI=K); 11) AMA CPT Assistant; 12) National Correct Coding Initiative Policy Manual; 13) Integrated Outpatient Code Editor (I/OCE) CMS Specifications Appendix L: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V20.0 Effective 01/01/2019), Appendix D: Computation of Discounting Fraction (OPPS only), and Appendix P: Pass-Through Drugs and Biologicals Processing (OPPS Only, V17.2); 14) CMS Hospital Outpatient PPS, Addendum B Updates, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	Complex	7/26/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 §414- Payment for Part B Medical and Other Health Services; 4) 42 CFR §419- Prospective Payment System for Hospital Outpatient Department 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) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 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 Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS) §§10.1- 10.5, 20, 40-61, 100, 120, 150-240, 270, and 300; 10) American Medical Association (AMA), Current Procedure Terminology, Coding and Payment, APC Payment Book, APC Grouping Logic: Comprehensive APCs (SI=J1) , APCs for Hospital Part B services paid through a comprehensive APC (SI = J1), Procedure or Service, Not Discounted When Multiple (SI=S), Procedure or Service, Multiple Reduction Applies (SI = T), and Nonpass-Through Drugs and Biologicals (SI=K); 11) AMA CPT Assistant; 12) National Correct Coding Initiative Policy Manual; 13) Integrated Outpatient Code Editor (I/OCE) CMS Specifications Appendix L: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V20.0 Effective 01/01/2019), Appendix D: Computation of Discounting Fraction (OPPS only), and Appendix P: Pass-Through Drugs and Biologicals Processing (OPPS Only, V17.2); 14) CMS Hospital Outpatient PPS, Addendum B Updates, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	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.	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	1) Social Security Act, Section 1833. Payment of Benefits [42 U.S.C. 1395l] (e); 2) Social Security Act, Section 1862. Exclusions from Coverage and Medicare as a Secondary Payer [42 U.S.C. 1395y] (a)(1)(A); 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30- Correct Coding Policy; 6) Medicare Claims Processing Manual, Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 7) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 8) Medicare Claims Processing Manual, Chapter 29- Appeals of Claims Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals (Rev. 4278, Effective 4/12/2019); 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) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html; 11) AMA CPT Code book	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.	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	1) Social Security Act, Section 1833. Payment of Benefits [42 U.S.C. 1395l] (e); 2) Social Security Act, Section 1862. Exclusions from Coverage and Medicare as a Secondary Payer [42 U.S.C. 1395y] (a)(1)(A); 3) 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4) 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30- Correct Coding Policy; 6) Medicare Claims Processing Manual, Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 7) Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 8) Medicare Claims Processing Manual, Chapter 29- Appeals of Claims Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals (Rev. 4278, Effective 4/12/2019); 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) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html; 11) AMA CPT Code book	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.	0105 - Physician Services during Hospice Period	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1) Title 18, Section 1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 2) CMS 100-02 Medicare Benefit Policy Manual, Chapter 9. Coverage of Hospice Services, Section 10 - Requirements; 3) CMS 100-02 Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3 - Physician Services; 4) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 10, Overview; 5) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 40.2, Processing Professional Claims for Hospice Beneficiaries; 6) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 50, Billing and Payment for Services Unrelated to Terminal Illness; 7) Code of Federal Regulations Title 42 PART 418.402-HOSPICE CARE-Individual Liability for Services that are not considered hospice care; 8) CMS Pub. 100-04 Medicare Claims Processing Manual,, Chapter 11, Section 20.1 & 30.3 https://ecfr.io/Title-42/pt42.3.418#se42.3.418_1402	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.	0105 - Physician Services during Hospice Period	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1) Title 18, Section 1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 2) CMS 100-02 Medicare Benefit Policy Manual, Chapter 9. Coverage of Hospice Services, Section 10 - Requirements; 3) CMS 100-02 Medicare Benefit Policy Manual, Chapter 9, Section 40.1.3 - Physician Services; 4) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 10, Overview; 5) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 40.2, Processing Professional Claims for Hospice Beneficiaries; 6) CMS 100-04 Medicare Claims Processing Manual, Chapter 11, Section 50, Billing and Payment for Services Unrelated to Terminal Illness; 7) Code of Federal Regulations Title 42 PART 418.402-HOSPICE CARE-Individual Liability for Services that are not considered hospice care; 8) CMS Pub. 100-04 Medicare Claims Processing Manual,, Chapter 11, Section 20.1 & 30.3 https://ecfr.io/Title-42/pt42.3.418#se42.3.418_1402	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.	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	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, §20.4.2- - Site of Service Payment Differential	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.	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	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, §20.4.2- - Site of Service Payment Differential	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.	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	1) Title XVIII, §§1833(d) and (e) of the Social Security Act- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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 Claims Processing Manual, CMS Publication 100-04, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 7)SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2018-Part-B-MAC-Update.html	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.	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	1) Title XVIII, §§1833(d) and (e) of the Social Security Act- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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 Claims Processing Manual, CMS Publication 100-04, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 7)SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2018-Part-B-MAC-Update.html	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	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), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 7) SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2019-Part-B-MAC-Update	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	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), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 7) SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2019-Part-B-MAC-Update	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, Outpatient Hospital, SNF	3 years prior to ADR Letter date	2 – all applicable states	1) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 2) Title XVIII, §§1862(a)(1)(A) and (a)(7) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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) §410.32(a)- Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions; 6) 42 Code of Federal Regulations (CFR) §411.15(k)(1)- Particular Services Excluded from Coverage; 7) Medicare National Coverage Determination Manual, Chapter 1, part 1, §20.32- Transcatheter Aortic Valve Replacement (TAVR); 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 Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests through §80.6.4- Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests; 10) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.4- Cardiovascular System (Codes 92950- 93799); 11) CGS LCD L34338- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2018; 12) First Coast LCD L33768- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised10/01/2018; 13) NGS LCD L33577- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2018; 14) Palmetto LCD L37379- Echocardiography; Effective 9/18/2017; Revised 6/20/2019; 15) American Medical Association (AMA), Current Procedural Terminology Manual, Coding Guidelines	Complex	9/28/2018	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 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, Outpatient Hospital, SNF	3 years prior to ADR Letter date	3 – all applicable states	1) Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 2) Title XVIII, §§1862(a)(1)(A) and (a)(7) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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) §410.32(a)- Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions; 6) 42 Code of Federal Regulations (CFR) §411.15(k)(1)- Particular Services Excluded from Coverage; 7) Medicare National Coverage Determination Manual, Chapter 1, part 1, §20.32- Transcatheter Aortic Valve Replacement (TAVR); 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 Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests through §80.6.4- Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests; 10) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.4- Cardiovascular System (Codes 92950- 93799); 11) CGS LCD L34338- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2018; 12) First Coast LCD L33768- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised10/01/2018; 13) NGS LCD L33577- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2018; 14) Palmetto LCD L37379- Echocardiography; Effective 9/18/2017; Revised 6/20/2019; 15) American Medical Association (AMA), Current Procedural Terminology Manual, Coding Guidelines	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. If a home dialysis patient receives dialysis in a dialysis center or other outpatient facility during the month, the MCP physician or practitioner is paid the management fee for the home dialysis patient and cannot bill the ESRD-related service codes for managing center based patients.	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	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 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §140- Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis; §140.1- Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients); and §140.4- Controlling Claims Paid Under the Monthly Capitation Payment Method; 7) American Medical Association (AMA), Current Procedural Terminology 2015 to current	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. If a home dialysis patient receives dialysis in a dialysis center or other outpatient facility during the month, the MCP physician or practitioner is paid the management fee for the home dialysis patient and cannot bill the ESRD-related service codes for managing center based patients.	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, 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 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §140- Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis; §140.1- Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients); and §140.4- Controlling Claims Paid Under the Monthly Capitation Payment Method; 7) American Medical Association (AMA), Current Procedural Terminology 2015 to current	Automated	11/7/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. 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	1) Title XVIII of the Social Security Act Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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: Publication 100-04; Chapter 1, § 120.2 (B); 6) Medicare Claims Processing Manual (CMS Publication 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), §10.5- Place of Service Codes and Definitions; 7) Medicare Benefit Policy Manual (CMS Publication 100-02), Chapter 15 (Covered Medical and Other Health Services), §30- Physician Services; 8) Medicare Claims Processing Manual: Publication 100-04; Chapter 1 (General Billing Requirements), § 120.2 (B) Exact Duplicates: Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)	Automated	10/17/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Home Visits for physician services should not overlap an active Inpatient Stay. 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	1) Title XVIII of the Social Security Act Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 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: Publication 100-04; Chapter 1, § 120.2 (B); 6) Medicare Claims Processing Manual (CMS Publication 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), §10.5- Place of Service Codes and Definitions; 7) Medicare Benefit Policy Manual (CMS Publication 100-02), Chapter 15 (Covered Medical and Other Health Services), §30- Physician Services; 8) Medicare Claims Processing Manual: Publication 100-04; Chapter 1 (General Billing Requirements), § 120.2 (B) Exact Duplicates: Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)	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 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	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 23; Addendum - MPFSDB Record Layouts 20 - Professional Component (PC)/Technical Component (TC) Indicator https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf	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	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 23; Addendum - MPFSDB Record Layouts 20 - Professional Component (PC)/Technical Component (TC) Indicator https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf	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."	0117 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	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	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) 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; 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) 42 CFR §411.15(k)(1)- Particular services excluded from coverage; 7) 42 CFR §424.5(a)(6)- Basic conditions- Sufficient information; 8) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9) National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	Automated	10/17/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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."	0117 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	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	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) 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; 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) 42 CFR §411.15(k)(1)- Particular services excluded from coverage; 7) 42 CFR §424.5(a)(6)- Basic conditions- Sufficient information; 8) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9) National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	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.	0118 - Arthroscopic Extensive Shoulder Debridement: Incorrect Coding	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	1) Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A) – Payment of Benefits; 2) 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) 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) 42 Code of Federal Regulations §§411.15(k)(1)- Particular Services Excluded from Coverage, 424.5(a)(6)- Basic Conditions; 6) Internet Only Manual, CMS Pub. 100-02 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- current 8) AMA CPT Codebook	Automated	10/16/2018	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.	0118 - Arthroscopic Extensive Shoulder Debridement: Incorrect Coding	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	1) Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A) – Payment of Benefits; 2) 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) 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) 42 Code of Federal Regulations §§411.15(k)(1)- Particular Services Excluded from Coverage, 424.5(a)(6)- Basic Conditions; 6) Internet Only Manual, CMS Pub. 100-02 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- current 8) AMA CPT Codebook	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	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 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 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) Local Coverage Determination; L34980 Lumbar Epidural Injections (Noridian – JF); Effective: 10/01/2015; Revision Effective: DOS on or after 10/01/2017; Revision effective 10/01/2019; 7) Local Coverage Determination; L34982 Lumbar Epidural injections (Noridian – JE); Effective: 10/01/2015; Revision Effective DOS on or after 10/01/2017; Revision effective 10/01/2019; 8) Local Coverage Determination; L36920 Epidural Injections for Pain Management (Novitas – JL & JH); Effective: 05/04/2017; Revision Effective DOS on or after 01/03/2019; Revision effective 11/21/2019	Complex	10/31/2018	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 an evaluation and management service billed with the CPT modifier "57" if it was provided on the day of or the day before a procedure with a 0-day or 10-day global surgical period. E&M Codes Included in the Global Package billed with Modifier 57 will be recovered as overpayments.	0120 - Modifier 57 for Procedure with a 0-Day or 10-Day Global Indicator: 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 Practitioner, § 30.6.6.C- Payment for Evaluation and Management Services Provided During Global Period of Surgery, CPT modifier '57' – Decision for Surgery Made Within Global Surgical Period	Automated	11/1/2018	Approved
Carriers may not pay for an evaluation and management service billed with the CPT modifier "57" if it was provided on the day of or the day before a procedure with a 0-day or 10-day global surgical period. E&M Codes Included in the Global Package billed with Modifier 57 will be recovered as overpayments.	0120 - Modifier 57 for Procedure with a 0-Day or 10-Day Global Indicator: 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 Practitioner, § 30.6.6.C- Payment for Evaluation and Management Services Provided During Global Period of Surgery, CPT modifier '57' – Decision for Surgery Made Within Global Surgical Period	Automated	11/1/2018	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.	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	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) American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions)	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.	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	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) American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions)	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.	0122 - Outpatient Hospice Related Services: Unbundling	Part A Outpatient	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 1861(dd)(1) Hospice Care; Hospice Program; 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 1833(e)- Payment of Benefits; 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) 42 CFR §418- Hospice Care; 7) CMS Claims Processing Manual, Chapter 11- Processing Hospice Claims, §10- Overview, §40.2- Processing Professional Claims for Hospice Beneficiaries, §50- Billing and Payment for Services Unrelated to Terminal Illness; 8) CMS Benefit Policy Manual 100-02, Chapter 9- Coverage of Hospice Services under Hospital Insurance, §10- Requirements, General	Automated	11/29/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.	0122 - Outpatient Hospice Related Services: Unbundling	Part A Outpatient	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 1861(dd)(1) Hospice Care; Hospice Program; 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 1833(e)- Payment of Benefits; 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) 42 CFR §418- Hospice Care; 7) CMS Claims Processing Manual, Chapter 11- Processing Hospice Claims, §10- Overview, §40.2- Processing Professional Claims for Hospice Beneficiaries, §50- Billing and Payment for Services Unrelated to Terminal Illness; 8) CMS Benefit Policy Manual 100-02, Chapter 9- Coverage of Hospice Services under Hospital Insurance, §10- Requirements, General	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.	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	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- 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 Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum- MPFSDB File Layouts, 2011-2018 File Layout; 6) Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, §30 Services Paid Under the Medicare Physician's Fee Schedule; 7) Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, §30.1 Provider-Based Physician Services	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.	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 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- 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 Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum- MPFSDB File Layouts, 2011-2018 File Layout; 6) Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, §30 Services Paid Under the Medicare Physician's Fee Schedule; 7) Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, §30.1 Provider-Based Physician Services	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.	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	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: CMS Publication 100-04; Chapter 23, Addendum-MPFSDB File, Layouts, 2001-2018 File Layout	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.	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	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: CMS Publication 100-04; Chapter 23, Addendum-MPFSDB File, Layouts, 2001-2018 File Layout	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.	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	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/ Nonphysician Practitioners, §190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services; 7) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.3 - List of Medicare Telehealth Services; 8) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.2 -Eligibility Criteria; 9) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.6 -Payment Methodology for Physician/Practitioner at the Distant; 10) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners	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.	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	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/ Nonphysician Practitioners, §190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services; 7) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.3 - List of Medicare Telehealth Services; 8) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.2 -Eligibility Criteria; 9) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.6 -Payment Methodology for Physician/Practitioner at the Distant; 10) Medicare Claims Processing Manual Chapter 12- Physician/ Nonphysician Practitioners, §190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners	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	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 12- Physician/Nonphysician Practitioners, §30- Correct Coding Policy, (E)- Separate Procedures, (G)- Family of Codes, and (H)- Most Extensive Procedures; 6) AMA CPT Manual Endoscopy Section; 2015 to current; 7) National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI – Digestive System CPT Codes 4000 - 4999, §C – Endoscopic Services	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	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 12- Physician/Nonphysician Practitioners, §30- Correct Coding Policy, (E)- Separate Procedures, (G)- Family of Codes, and (H)- Most Extensive Procedures; 6) AMA CPT Manual Endoscopy Section; 2015 to current; 7) National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI – Digestive System CPT Codes 4000 - 4999, §C – Endoscopic Services	Automated	11/14/2018	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, 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 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) is medically necessary according to Medicare coverage indications.	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	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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 7) 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); 8) CMS National Coverage Determination Manual, Ch.1, §20.29 Hyperbaric Oxygen Therapy, Effective 4/03/2017; Implemented 12/18/2017; 9) Novitas LCD L35021- Hyperbaric Oxygen (HBO) Therapy; Effective 10/01/2015; Revised 07/25/2019; 10) Annual American Medical Association CPT Manual, Coding Guidelines	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 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) is medically necessary according to Medicare coverage indications.	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; 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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 7) 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); 8) CMS National Coverage Determination Manual, Ch.1, §20.29 Hyperbaric Oxygen Therapy, Effective 4/03/2017; Implemented 12/18/2017; 9) Novitas LCD L35021- Hyperbaric Oxygen (HBO) Therapy; Effective 10/01/2015; Revised 07/25/2019; 10) Annual American Medical Association CPT Manual, Coding Guidelines	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	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) Title XVIII of the Social Security Act (SSA): 1862(a)(10); 4) 42 CFR §411.15 Particular services excluded from coverage, (k)(1); 5) 42 CFR §424.5 Basic conditions, (a)(6) Sufficient information; 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 Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 10) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §120 – Cosmetic Surgery; 11) Medicare Claims Processing Manual Chapter 12 Physicians/Nonphysician Practitioners, §40.6 Claims for Multiple Surgeries (A) General; 12) National Correct Coding Initiative Policy Manual, Chapter 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 7, Revised 1/1/2019; 13) National Correct Coding Initiative Policy Manual, Chapter 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 8, Revised 1/1/2019; 14) Novitas LCD L35090: Cosmetic and Reconstructive Surgery, Effective 10/1/2015; Revised 4/14/2017; 15) WPS L34698: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 01/01/2018; 02/01/2016; 10/01/2016; 01/01/2017; 16) Palmetto GBA L33428: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 10/1/2018; 17) Noridian LCD L35163: Plastic Surgery, Effective 10/1/2015; Revised 10/10/2017; 18) Noridian LCD L37020: Plastic Surgery, Effective 10/10/2017; 19) Annual American Medical Association: CPT Manual	Complex	2/13/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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) Title XVIII of the Social Security Act (SSA): 1862(a)(10); 4) 42 CFR §411.15 Particular services excluded from coverage, (k)(1); 5) 42 CFR §424.5 Basic conditions, (a)(6) Sufficient information; 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 Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 10) Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §120 – Cosmetic Surgery; 11) Medicare Claims Processing Manual Chapter 12 Physicians/Nonphysician Practitioners, §40.6 Claims for Multiple Surgeries (A) General; 12) National Correct Coding Initiative Policy Manual, Chapter 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 7, Revised 1/1/2019; 13) National Correct Coding Initiative Policy Manual, Chapter 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 8, Revised 1/1/2019; 14) Novitas LCD L35090: Cosmetic and Reconstructive Surgery, Effective 10/1/2015; Revised 4/14/2017; 15) WPS L34698: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 01/01/2018; 02/01/2016; 10/01/2016; 01/01/2017; 16) Palmetto GBA L33428: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 10/1/2018; 17) Noridian LCD L35163: Plastic Surgery, Effective 10/1/2015; Revised 10/10/2017; 18) Noridian LCD L37020: Plastic Surgery, Effective 10/10/2017; 19) Annual American Medical Association: CPT Manual	Complex	2/13/2019	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	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) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215), (C) Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility; 3) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.11 Emergency Department Visits (Codes 99281 - 99288), (D) Emergency Department or Office/Outpatient Visits on Same Day As Nursing Facility Admission; 4) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.13 Nursing Facility Services, (A) Visits to Perform the Initial Comprehensive Assessment and Annual Assessments	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	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215), (C) Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility; 3) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.11 Emergency Department Visits (Codes 99281 - 99288), (D) Emergency Department or Office/Outpatient Visits on Same Day As Nursing Facility Admission; 4) Medicare Claims Processing Manual: Publication 100-04; Chapter 12 Physicians/Nonphysician Practitioners, §30.6.13 Nursing Facility Services, (A) Visits to Perform the Initial Comprehensive Assessment and Annual Assessments	Automated	2/5/2019	Approved
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer).	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	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: CMS Publication 100-04; Chapter 13, § 60.3.1 – Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; 7) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 13, § 60.3.2 – Tracer Codes Required for Positron Emission Tomography (PET Scans); effective 01-01-18; 8) CMS Manual System – Transmittal 3911; Change Request 10319 – Subject: New Positron Emission Tomography (PET) Radiopharmaceutical/Tracer Unclassified Codes; effective 01-01-18	Automated	2/5/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer).	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)- 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: CMS Publication 100-04; Chapter 13, § 60.3.1 – Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; 7) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 13, § 60.3.2 – Tracer Codes Required for Positron Emission Tomography (PET Scans); effective 01-01-18; 8) CMS Manual System – Transmittal 3911; Change Request 10319 – Subject: New Positron Emission Tomography (PET) Radiopharmaceutical/Tracer Unclassified Codes; effective 01-01-18	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	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) CMS Claims Processing Manual, Pub 100-04, Ch. 32, §180 Cryosurgery of the Prostate Gland (Rev. 2998, Issued 7/25/2014, Effective Upon Implementation of ICD-10); 4) 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; 5) 42 CFR §405.986 Good Cause for Reopening; 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) CMS National Coverage Determinations Manual (NCD), Pub 100-03, Part 4, §230.9 Cryosurgery of Prostate (Rev. 1, 10-03-03).	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	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) CMS Claims Processing Manual, Pub 100-04, Ch. 32, §180 Cryosurgery of the Prostate Gland (Rev. 2998, Issued 7/25/2014, Effective Upon Implementation of ICD-10); 4) 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; 5) 42 CFR §405.986 Good Cause for Reopening; 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) CMS National Coverage Determinations Manual (NCD), Pub 100-03, Part 4, §230.9 Cryosurgery of Prostate (Rev. 1, 10-03-03).	Complex	2/5/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcome assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meeting 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	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(s)(2)(CC)(eee)(1)- Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program; 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) 42 CFR §410.49 – Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage; 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) Medicare National Coverage Determinations (NCD), Part 1 - Coverage Determinations, § 20.10.1 - Cardiac Rehabilitation Programs for Chronic Heart Failure; §20.31 - Intensive Cardiac Rehabilitation (ICR) Programs; §20.31.1 - Pritikin Program; §20.31.2 - Ornish Program for Reversing Heart Disease; §20.31.3 – Benson-Henry Institute Cardiac Wellness Program; 9) Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §232 - Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010; 10) Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, § 140 - Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs; 11) Palmetto LCD L34412- Cardiac Rehabilitation, Effective 10/01/2015; Retired 4/5/2019; 12) Palmetto LCA A53775- Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation, Effective 10/01/2015; Revised 4/5/2019	Complex	3/7/2019	Approved
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcome assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meeting 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	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(s)(2)(CC)(eee)(1)- Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program; 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) 42 CFR §410.49 – Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage; 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) Medicare National Coverage Determinations (NCD), Part 1 - Coverage Determinations, § 20.10.1 - Cardiac Rehabilitation Programs for Chronic Heart Failure; §20.31 - Intensive Cardiac Rehabilitation (ICR) Programs; §20.31.1 - Pritikin Program; §20.31.2 - Ornish Program for Reversing Heart Disease; §20.31.3 – Benson-Henry Institute Cardiac Wellness Program; 9) Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §232 - Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010; 10) Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, § 140 - Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs; 11) Palmetto LCD L34412- Cardiac Rehabilitation, Effective 10/01/2015; Retired 4/5/2019; 12) Palmetto LCA A53775- Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation, Effective 10/01/2015; Revised 4/5/2019	Complex	3/7/2019	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.	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	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) 42 CFR §411.15(a)(1) – Particular services excluded from coverage,(a) Routine physical checkups (1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening; 7) 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 8) 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.; 9) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §§80.4-80.4.4- Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 10) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions.; 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, §3.4.1.3- Diagnosis Code Requirements; 13) 6/22/2018; 14) Current Procedural Terminology Manual	Complex	4/15/2019	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.	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; 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 CFR §411.15(a)(1) – Particular services excluded from coverage,(a) Routine physical checkups (1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening; 7) 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 8) 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.; 9) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §§80.4-80.4.4- Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 10) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions.; 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, §3.4.1.3- Diagnosis Code Requirements; 13) 6/22/2018; 14) Current Procedural Terminology Manual	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	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: Publication 100-04; Chapter 6; 10.3 – Types of Services Subject to the Consolidated Billing Requirement for SNF; 20.5- Therapy Services; 7) Medicare Claims Processing Manual: Publication 100-04; Chapter 7; 110, Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay	Automated	2/20/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 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: Publication 100-04; Chapter 6; 10.3 – Types of Services Subject to the Consolidated Billing Requirement for SNF; 20.5- Therapy Services; 7) Medicare Claims Processing Manual: Publication 100-04; Chapter 7; 110, Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay	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.	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	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; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1842(p)(4)- Provisions Relating to the Administration of Part B; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); 6) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(10); 7) 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; 8) 42 CFR §405.986- Good Cause for Reopening; 9) CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §10- General Exclusions from Coverage; 10) CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 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) First Coast Service Options (FCSO) Local Coverage Determination (LCD) L34976 Vertebroplasty, Vertebral Augmentation; Percutaneous, Effective 10/01/2015; Revised 01/22/2019; 13) Novitas LCD L35130 Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous, Effective 10/01/2015; Revised 04/25/2019; 14) Palmetto LCD L33473 Vertebroplasty/Kyphoplasty, Effective 10/01/2015; Revised 08/08/2019; 15) WPS LCD L34592 Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation, Effective 10/01/2015; Revised 11/01/2018; 16) NGS LCD L33569 Vertebroplasty and Vertebral Augmentation (Percutaneous), Effective 10/01/2015; 17) Noridian LCD L34106 Percutaneous Vertebral Augmentation, Effective 10/01/2015; 18) Noridian LCD L34228, Percutaneous Vertebral Augmentation, Effective 10/01/2015; 19) CGS LCD L34048 Vertebroplasty and Vertebral Augmentation (Percutaneous), Effective 10/01/2015, Revised 08/15/2019; 20) Palmetto GBA LCA A56819 Billing and Coding: Vertebroplasty/Kyphoplasty, Effective 8/8/2019; 21) Annual American Medical Association: CPT Manual	Complex	2/20/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1842(p)(4)- Provisions Relating to the Administration of Part B; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); 6) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(10); 7) 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; 8) 42 CFR §405.986- Good Cause for Reopening; 9) CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §10- General Exclusions from Coverage; 10) CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 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) First Coast Service Options (FCSO) Local Coverage Determination (LCD) L34976 Vertebroplasty, Vertebral Augmentation; Percutaneous, Effective 10/01/2015; Revised 01/22/2019; 13) Novitas LCD L35130 Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous, Effective 10/01/2015; Revised 04/25/2019; 14) Palmetto LCD L33473 Vertebroplasty/Kyphoplasty, Effective 10/01/2015; Revised 08/08/2019; 15) WPS LCD L34592 Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation, Effective 10/01/2015; Revised 11/01/2018; 16) NGS LCD L33569 Vertebroplasty and Vertebral Augmentation (Percutaneous), Effective 10/01/2015; 17) Noridian LCD L34106 Percutaneous Vertebral Augmentation, Effective 10/01/2015; 18) Noridian LCD L34228, Percutaneous Vertebral Augmentation, Effective 10/01/2015; 19) CGS LCD L34048 Vertebroplasty and Vertebral Augmentation (Percutaneous), Effective 10/01/2015, Revised 08/15/2019; 20) Palmetto GBA LCA A56819 Billing and Coding: Vertebroplasty/Kyphoplasty, Effective 8/8/2019; 21) Annual American Medical Association: CPT Manual	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	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) § 1861 (s)(2)(CC)(fff)- Part E Miscellaneous Provisions- Definitions of Services, Institutions, ETC.- Pulmonary Rehabilitation Program; 4) 42 Code of Federal Regulations §§ 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5) 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; 6) 42 Code of Federal Regulations §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; 8) Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, Section 231 – Pulmonary Rehabilitation (PR) Program Services Furnished on or After January 1, 2010.; 9) Medicare Claim Processing Manual, Chapter 32 – Billing Requirements for Special Services, Section 140 – Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs.; 10) Noridian LCA A52770 Pulmonary Rehabilitation, original effective date 10/01/2015, Revision Date 10/08/2018; 11) Noridian LCA A56152 Pulmonary Rehabilitation, original effective date 10/08/2018	Complex	3/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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) § 1861 (s)(2)(CC)(fff)- Part E Miscellaneous Provisions- Definitions of Services, Institutions, ETC.- Pulmonary Rehabilitation Program; 4) 42 Code of Federal Regulations §§ 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5) 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; 6) 42 Code of Federal Regulations §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; 8) Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, Section 231 – Pulmonary Rehabilitation (PR) Program Services Furnished on or After January 1, 2010.; 9) Medicare Claim Processing Manual, Chapter 32 – Billing Requirements for Special Services, Section 140 – Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs.; 10) Noridian LCA A52770 Pulmonary Rehabilitation, original effective date 10/01/2015, Revision Date 10/08/2018; 11) Noridian LCA A56152 Pulmonary Rehabilitation, original effective date 10/08/2018	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 for years: 2015, 2016, 2017 and 2018 are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services 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	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 6- Inpatient Part A Billing and SNF Consolidated Billing, § 20.1.2- Other Excluded Services Beyond the Scope of a SNF Part A Benefit https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 7) Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 110.2.7- Edit to Prevent Payment of Facility Fees for Services Billed by an Ambulatory Surgical Center (ASC) when Rendered to a Beneficiary in a Part A Stay https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 8) Office of Inspector General (OIG) Report: Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008 (A-01-0900521) December 2010 https://oig.hhs.gov/oas/reports/region1/10900521.pdf; 9) SNF Consolidated Billing – Annual Updates for Part A MAC – 2015, 2016, 2017, 2018 and 2019 https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2015-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2016-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2017-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2018-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2019-Part-A-MAC-Update.html; 10) SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2019-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2018-General-Explanation.pdf	Automated	4/2/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 for years: 2015, 2016, 2017 and 2018 are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services 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	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 6- Inpatient Part A Billing and SNF Consolidated Billing, § 20.1.2- Other Excluded Services Beyond the Scope of a SNF Part A Benefit https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 7) Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 110.2.7- Edit to Prevent Payment of Facility Fees for Services Billed by an Ambulatory Surgical Center (ASC) when Rendered to a Beneficiary in a Part A Stay https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 8) Office of Inspector General (OIG) Report: Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008 (A-01-0900521) December 2010 https://oig.hhs.gov/oas/reports/region1/10900521.pdf; 9) SNF Consolidated Billing – Annual Updates for Part A MAC – 2015, 2016, 2017, 2018 and 2019 https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2015-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2016-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2017-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2018-Part-A-MAC-Update.html https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2019-Part-A-MAC-Update.html; 10) SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2019-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2018-General-Explanation.pdf	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 Noridian LCDs L34209 and L34010, First Coast LCDs L33762, LCAs A56064 and A55963, NGS L33575 and A52870, Novitas L34924 and A55229, Palmetto L33454, WPS L34536, and CGS L34082	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity, Unbundling, 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	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) 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) CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 1/01/2018; 7) First Coast LCD L33762- Treatment of Varicose Veins of the Lower Extremity; Effective 10/1/2015; Revised 01/22/2019; 8) NGS LCD L33575- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 8/01/2019; 9) Noridian LCD L34209- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 1/1/2018; 10) Noridian LCD L34010- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 1/1/2018; 11) Novitas LCD L34924- Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities; Effective 10/1/2015, Revised 4/18/2019; 12) Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 4/22/2019; 13) WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 8/20/2019; 14) First Coast LCA A55963- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 4/17/2018; 15) First Coast LCA A56064- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 7/10/2018; 16) NGS LCA A52870- Varicose Veins of the Lower Extremity, Treatment of- Supplemental Instructions Article; Effective 10/1/2015; Revised 8/01/2019; 17 Novitas A55229- Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities; Effective 8/11/2016; Revised 5/17/2018	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 Noridian LCDs L34209 and L34010, First Coast LCDs L33762, LCAs A56064 and A55963, NGS L33575 and A52870, Novitas L34924 and A55229, Palmetto L33454, WPS L34536, and CGS L34082	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity, Unbundling, 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	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) 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) CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 1/01/2018; 7) First Coast LCD L33762- Treatment of Varicose Veins of the Lower Extremity; Effective 10/1/2015; Revised 01/22/2019; 8) NGS LCD L33575- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 8/01/2019; 9) Noridian LCD L34209- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 1/1/2018; 10) Noridian LCD L34010- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 1/1/2018; 11) Novitas LCD L34924- Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities; Effective 10/1/2015, Revised 4/18/2019; 12) Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 4/22/2019; 13) WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 8/20/2019; 14) First Coast LCA A55963- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 4/17/2018; 15) First Coast LCA A56064- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 7/10/2018; 16) NGS LCA A52870- Varicose Veins of the Lower Extremity, Treatment of- Supplemental Instructions Article; Effective 10/1/2015; Revised 8/01/2019; 17 Novitas A55229- Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities; Effective 8/11/2016; Revised 5/17/2018	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	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) 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/Non-physician Practitioners, Section 30- Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures (Effective 10/1/03); 7) Medicare Claims Processing Manual, Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.2- Limiting Charge and CCI Edits; 8) NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9) CPT Manual year 2015 to current	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	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) 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/Non-physician Practitioners, Section 30- Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures (Effective 10/1/03); 7) Medicare Claims Processing Manual, Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.2- Limiting Charge and CCI Edits; 8) NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9) CPT Manual year 2015 to current	Automated	3/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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. 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/Non-physician Practitioners, Sections 30 – Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures (Effective 10/1/03); 7. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.2 Limiting Charge and CCI Edits; 8. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9. CPT Manual year 2015 to current	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	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. 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/Non-physician Practitioners, Sections 30 – Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures (Effective 10/1/03); 7. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.2 Limiting Charge and CCI Edits; 8. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9. CPT Manual year 2015 to current	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	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; Publication 100-04; Chapter 12, Section 30.6.9.2 (C) Subsequent Hospital Visit and Discharge Management on Same Day	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	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; Publication 100-04; Chapter 12, Section 30.6.9.2 (C) Subsequent Hospital Visit and Discharge Management on Same Day	Automated	4/22/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 performing 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 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.	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	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 §3.6.2.4 Coding Determinations; 6) AHA Coding Clinic for HCPCS, Third Quarter 2013, Volume 13, Number 3, Page 1 Reporting MOHS micrographic surgery (MMS); 7) CPT Assistant, October 2014, Volume 24, Issue 10, Page 14 Frequently Asked Questions, Mohs Surgery, Tissue Block; 8) CPT Assistant, November 2006, Volume 16, Issue 11, Pages 1-7 Mohs Micrographic Surgery; 9) CPT Assistant, February 2014, Volume 24, Issue 2, Page 10 Coding Clarification: Mohs Surgery	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 performing 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 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.	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; 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 §3.6.2.4 Coding Determinations; 6) AHA Coding Clinic for HCPCS, Third Quarter 2013, Volume 13, Number 3, Page 1 Reporting MOHS micrographic surgery (MMS); 7) CPT Assistant, October 2014, Volume 24, Issue 10, Page 14 Frequently Asked Questions, Mohs Surgery, Tissue Block; 8) CPT Assistant, November 2006, Volume 16, Issue 11, Pages 1-7 Mohs Micrographic Surgery; 9) CPT Assistant, February 2014, Volume 24, Issue 2, Page 10 Coding Clarification: Mohs Surgery	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 MPGS 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	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 §414- Payment for Part B Medical and other Health Services, Subpart A – General Provisions, Subpart B – Physicians and other Practitioners, Subpart E – Determination of Reasonable Charges under ESRD Program; 6) 42 CFR §414.40- Coding and Ancillary Policies; 7) 42 CFR §415- Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings; 8) 42 CFR §419.44- Payment Reductions for Procedures; 9) Medicare Claims Processing Manual, Chapter 12- Physicians/Non-physician Practitioners; 10) Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements; 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, §3.6.2.4- Coding Determinations; 13) American Medical Association (AMA), Current Procedural Terminology (CPT); 14) American Medical Association, Healthcare Common Procedure Coding System Level II; 15) American Medical Association Current Procedural Terminology Assistant; 16) National Correct Coding Initiatives (NCCI) Policy Manual; 17) 1995 & 1997 Documentation Guidelines for Evaluation & Management Services; 18) CMS Physician Fee Schedule, Relative Value Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	Complex	4/24/2019	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.	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 §405.980- 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 §414- Payment for Part B Medical and other Health Services, Subpart A – General Provisions, Subpart B – Physicians and other Practitioners, Subpart E – Determination of Reasonable Charges under ESRD Program; 6) 42 CFR §414.40- Coding and Ancillary Policies; 7) 42 CFR §415- Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings; 8) 42 CFR §419.44- Payment Reductions for Procedures; 9) Medicare Claims Processing Manual, Chapter 12- Physicians/Non-physician Practitioners; 10) Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements; 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, §3.6.2.4- Coding Determinations; 13) American Medical Association (AMA), Current Procedural Terminology (CPT); 14) American Medical Association, Healthcare Common Procedure Coding System Level II; 15) American Medical Association Current Procedural Terminology Assistant; 16) National Correct Coding Initiatives (NCCI) Policy Manual; 17) 1995 & 1997 Documentation Guidelines for Evaluation & Management Services; 18) CMS Physician Fee Schedule, Relative Value Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	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	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 § 414.B Payment for Part B Medical and Other Health Services- Coding and Ancillary Policies; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §3.6.2.4- Coding Determinations; 8) Medicare Claims Processing Manual, Chapter 12- Physician/ Non-physician Practitioners § 40.1- Definition of a Global Surgical Package; 9) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §20.3- Rebundling of CPT Codes; 40.1- Payment to Ambulatory Surgical Centers for non-ASC Services; 40.5- Payment for Multiple Procedures; 10) American Medical Association (AMA), Current Procedure Terminology; 11) ASC Payment System; Addendum AA; Payment indicators A2 (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight), G2 (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight); J8 (Device-intensive procedure; paid at adjusted rate. ASC Payment rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html; 12) National Correct Coding Initiative Policy Manual; 13) American Medical Association CPT Assistant; 14) American Hospital Association Coding Clinic for HCPCS	Complex	5/28/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 § 414.B Payment for Part B Medical and Other Health Services- Coding and Ancillary Policies; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §3.6.2.4- Coding Determinations; 8) Medicare Claims Processing Manual, Chapter 12- Physician/ Non-physician Practitioners § 40.1- Definition of a Global Surgical Package; 9) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §20.3- Rebundling of CPT Codes; 40.1- Payment to Ambulatory Surgical Centers for non-ASC Services; 40.5- Payment for Multiple Procedures; 10) American Medical Association (AMA), Current Procedure Terminology; 11) ASC Payment System; Addendum AA; Payment indicators A2 (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight), G2 (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight); J8 (Device-intensive procedure; paid at adjusted rate. ASC Payment rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html; 12) National Correct Coding Initiative Policy Manual; 13) American Medical Association CPT Assistant; 14) American Hospital Association Coding Clinic for HCPCS	Complex	5/28/2019	Approved
Medicare pays for nonemergency 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.	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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR 410.40- Coverage of ambulance services, (b) Levels of service; 10) 42 CFR 410.40- Coverage of ambulance services, (d) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis; 11) 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements; 12) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary; 13) 42 CFR 424.36- Signature Requirements; 14) 42 CFR 414.605 Definitions; 15) 42 CFR 414.610 Basis of Payment; 16) 42 CFR 411.15 (k)(1) Particular Services Excluded from Coverage, Any Services not Reasonable and Necessary; 17) 42 CFR 424.36 Signature Requirements and 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 18) 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; 19) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21) Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 11/14/2019; 22) First Coast Service Options (FCSO), LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 23) FCSO, LCD L33383, Non-Emergency Ground Ambulance Services. Effective Date 10/1/2015. Retirement Date 6/28/2018; 24) FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services. Effective Date 6/28/2018. Revised 02/19/2019; 25) Palmetto LCD L34549, Ambulance Services	Complex	5/22/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare pays for nonemergency 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.	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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR 410.40- Coverage of ambulance services, (b) Levels of service; 10) 42 CFR 410.40- Coverage of ambulance services, (d) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis; 11) 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements; 12) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary; 13) 42 CFR 424.36- Signature Requirements; 14) 42 CFR 414.605 Definitions; 15) 42 CFR 414.610 Basis of Payment; 16) 42 CFR 411.15 (k)(1) Particular Services Excluded from Coverage, Any Services not Reasonable and Necessary; 17) 42 CFR 424.36 Signature Requirements and 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 18) 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; 19) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20) Medicare Claims Processing Manual, Chapter 15- Ambulance, §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21) Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 11/14/2019; 22) First Coast Service Options (FCSO), LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 23) FCSO, LCD L33383, Non-Emergency Ground Ambulance Services. Effective Date 10/1/2015. Retirement Date 6/28/2018; 24) FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services. Effective Date 6/28/2018. Revised 02/19/2019; 25) Palmetto LCD L34549, Ambulance Services	Complex	5/22/2019	Approved
The outpatient code editor (OCE) has designated specific code pairs for device to procedure edits. The medical record will be reviewed to ensure the device billed on the claim corresponds with the correct procedure and did not bypass an edit inappropriately. In addition, the record will be reviewed to determine the number of units billed are supported in the record for each procedure performed.	0156 - Pass-Through Payment Device: Incorrect Coding	Outpatient Hospital; 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 Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.2.3- Comprehensive APCs; §60.1- Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPPS; §60.4- General Coding and Billing Instructions and Explanations; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 8) American Medical Association (AMA), Current Procedure Terminology, Coding and Payment; 9) American Medical Association Healthcare Common Procedure Coding System (HCPCS); 10) APC Payment Book, APC Grouping Logic: Status Indicator H = Pass-Through Devices Separate cost-based pass-through payment; not subject to copayment.; 11) ASC Addendum AA Payment Indicator J7 OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.; 12) Integrated OCE (IOCE) Quarterly Data Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html	Complex	9/25/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The outpatient code editor (OCE) has designated specific code pairs for device to procedure edits. The medical record will be reviewed to ensure the device billed on the claim corresponds with the correct procedure and did not bypass an edit inappropriately. In addition, the record will be reviewed to determine the number of units billed are supported in the record for each procedure performed.	0156 - Pass-Through Payment Device: Incorrect Coding	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, 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 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.2.3- Comprehensive APCs; §60.1- Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPPS; §60.4- General Coding and Billing Instructions and Explanations; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 8) American Medical Association (AMA), Current Procedure Terminology, Coding and Payment; 9) American Medical Association Healthcare Common Procedure Coding System (HCPCS); 10) APC Payment Book, APC Grouping Logic: Status Indicator H = Pass-Through Devices Separate cost-based pass-through payment; not subject to copayment.; 11) ASC Addendum AA Payment Indicator J7 OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.; 12) Integrated OCE (IOCE) Quarterly Data Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html	Complex	9/25/2019	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	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) 42 CFR §414.40 Coding and Ancillary Policies; 3) 42 CFR §419.44 Payment Reductions for Procedures; 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 §3.6.2.4- Coding Determinations; 7) Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.5- Discounting; §20.6- Use of Modifiers, §20.6.1- Where to Report Modifiers on the Hospital Part B Claim, and §20.6.4- Use of Modifiers for Discontinued Services; 8) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40.4- Payment for Terminated Procedures; 9) Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 10) American Medical Association (AMA), Current Procedural Terminology, Appendix A Modifiers; 11) AHA Coding Clinic for HCPCS 2007, Volume 7, Number 1, Page 1- Use of Modifiers 52, 73, and 74 and Anesthesia Reporting under OPPS; 12) AHA Coding Clinic for HCPCS 2008, Volume 8, Number 2, Pages 1-4- Special Issue: Modifiers 52, 73, and 74; 13) AHA Coding Clinic for HCPCS 2016, Volume 16, Number 1, Page 12- Appropriate Use of Modifiers for Discontinued Services under the OPPS; 14) AMA CPT Assistant, September 2003, Page 3- Hospital Outpatient Reporting Part IV: Use of the CPT Modifiers '52,' '58,' '59,' '73,' '74,' '76,' '77,' '78,' and '91'	Complex	6/28/2019	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	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) 42 CFR §414.40 Coding and Ancillary Policies; 3) 42 CFR §419.44 Payment Reductions for Procedures; 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 §3.6.2.4- Coding Determinations; 7) Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §10.5- Discounting; §20.6- Use of Modifiers, §20.6.1- Where to Report Modifiers on the Hospital Part B Claim, and §20.6.4- Use of Modifiers for Discontinued Services; 8) Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40.4- Payment for Terminated Procedures; 9) Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 10) American Medical Association (AMA), Current Procedural Terminology, Appendix A Modifiers; 11) AHA Coding Clinic for HCPCS 2007, Volume 7, Number 1, Page 1- Use of Modifiers 52, 73, and 74 and Anesthesia Reporting under OPPS; 12) AHA Coding Clinic for HCPCS 2008, Volume 8, Number 2, Pages 1-4- Special Issue: Modifiers 52, 73, and 74; 13) AHA Coding Clinic for HCPCS 2016, Volume 16, Number 1, Page 12- Appropriate Use of Modifiers for Discontinued Services under the OPPS; 14) AMA CPT Assistant, September 2003, Page 3- Hospital Outpatient Reporting Part IV: Use of the CPT Modifiers '52,' '58,' '59,' '73,' '74,' '76,' '77,' '78,' and '91'	Complex	6/28/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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	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 10- Home Health Agency Billing, §20- Home Health Prospective Payment System (HH PPS) Consolidated Billing; 7) Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20.2.2 - Therapy Editing	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.	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	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 10- Home Health Agency Billing, §20- Home Health Prospective Payment System (HH PPS) Consolidated Billing; 7) Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20.2.2 - Therapy Editing	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	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) American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 – current (Special Ophthalmological Services)	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	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) American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 – current (Special Ophthalmological Services)	Automated	6/19/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medical documentation will be reviewed to determine if the use of intravenous immune globulin meets Medicare coverage criteria and is medically reasonable and necessary.	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	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 13- Local Coverage Determinations, Section 13.5.1 Reasonable and Necessary Provisions in LCDs; 6) Medicare National Coverage Determinations (NCD) Manual, Part 4- Coverage Determinations, Section 250.3- Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases. Effective upon Implementation of ICD-10; 7) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, Section 80.6- Intravenous Immune Globulin; 8) CGS Administrators LCD L35891- Intravenous Immune Globulin; Effective 10/01/2015; Revised 03/01/2019; 9) First Coast Service Options (FCSO) LCD L34007- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 02/19/2019; 10) Noridian Healthcare Solutions LCD L34314- Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 07/01/2018; 11) Noridian Healthcare Solutions LCD L34074- Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 07/01/2018; 12) Novitas LCD L35093- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 04/11/2019; 13) Palmetto GBA L34580- Intravenous Immunoglobulin (IVIG); Effective 10/01/2015; Revised 07/26/2018; 14) WPS LCD L34771- Immune Globulins; Effective 10/01/2015; Revised 01/01/2019; 15) NGS LCA A52446- Intravenous Immune Globulin; Effective 10/01/2015; Revised 10/01/2017	Complex	8/20/2019	Approved
Medical documentation will be reviewed to determine if the use of intravenous immune globulin meets Medicare coverage criteria and is medically reasonable and necessary.	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	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 13- Local Coverage Determinations, Section 13.5.1 Reasonable and Necessary Provisions in LCDs; 6) Medicare National Coverage Determinations (NCD) Manual, Part 4- Coverage Determinations, Section 250.3- Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases. Effective upon Implementation of ICD-10; 7) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, Section 80.6- Intravenous Immune Globulin; 8) CGS Administrators LCD L35891- Intravenous Immune Globulin; Effective 10/01/2015; Revised 03/01/2019; 9) First Coast Service Options (FCSO) LCD L34007- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 02/19/2019; 10) Noridian Healthcare Solutions LCD L34314- Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 07/01/2018; 11) Noridian Healthcare Solutions LCD L34074- Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 07/01/2018; 12) Novitas LCD L35093- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 04/11/2019; 13) Palmetto GBA L34580- Intravenous Immunoglobulin (IVIG); Effective 10/01/2015; Revised 07/26/2018; 14) WPS LCD L34771- Immune Globulins; Effective 10/01/2015; Revised 01/01/2019; 15) NGS LCA A52446- Intravenous Immune Globulin; Effective 10/01/2015; Revised 10/01/2017	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 & Diagnostic Infusions: Incorrect Coding and Documentation Requirements	Outpatient Hospital	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 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals; 7) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §90.2- Drugs, Biologicals, and Radiopharmaceuticals; 8) Annual CPT Manual	Complex	11/18/2019	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 correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic & 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; 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; 7) Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §90.2- Drugs, Biologicals, and Radiopharmaceuticals; 8) Annual CPT Manual	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	1) SSA, §1862(a)(1)(A), §1862(a)(7) – Exclusions from coverage; 2) SSA, §1833(e) – Payment of benefits; 3) 42 CFR §411.15(a)(1) – Particular services excluded from coverage; Routine physical checkups; 4) 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 5) 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 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 Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 9) Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations 220- Radiology; 220.1- Computed Tomography (CT) §A- General, and §F- Computed Tomographic Angiography (CTA); 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnoses Code Requirement; 12) CPT Manual	Complex	7/22/2019	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	3 – all applicable states	1) SSA, §1862(a)(1)(A), §1862(a)(7) – Exclusions from coverage; 2) SSA, §1833(e) – Payment of benefits; 3) 42 CFR §411.15(a)(1) – Particular services excluded from coverage; Routine physical checkups; 4) 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 5) 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 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 Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 9) Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations 220- Radiology; 220.1- Computed Tomography (CT) §A- General, and §F- Computed Tomographic Angiography (CTA); 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnoses Code Requirement; 12) CPT Manual	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	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3) Title XVIII, §1861(dd)(1) of the Social Security Act- Hospice Care; Hospice Program; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews; 5) 42 CFR §405.986- Good Cause for Reopening; 6) 42 Code of Federal Regulations (CFR) §418.54(a)- Standard: Initial Assessment; 7) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 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 Benefit Policy Manual, Chapter 9- Coverage of Hospice Services Under Hospital Insurance, §40.1.9- Other Items and Services; 10) Medicare Claims Processing Manual, Chapter 11- Processing Hospice Claims, §50- Billing and Payment for Services Unrelated to Terminal Illness	Automated	7/23/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	1) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2) Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3) Title XVIII, §1861(dd)(1) of the Social Security Act- Hospice Care; Hospice Program; 4) 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews; 5) 42 CFR §405.986- Good Cause for Reopening; 6) 42 Code of Federal Regulations (CFR) §418.54(a)- Standard: Initial Assessment; 7) 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 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 Benefit Policy Manual, Chapter 9- Coverage of Hospice Services Under Hospital Insurance, §40.1.9- Other Items and Services; 10) Medicare Claims Processing Manual, Chapter 11- Processing Hospice Claims, §50- Billing and Payment for Services Unrelated to Terminal Illness	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	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: CMS Publication 100-04; Chapter 23, Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts, File Layout thru 2018 http://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/clm104c23.pdf; 7) Medicare Claims Processing Manual: CMS Publication 100-04, Chapter 12, §40.7 – Claims for Bilateral Surgeries C. 3. (Effective 10/01/03) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf	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	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: CMS Publication 100-04; Chapter 23, Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts, File Layout thru 2018 http://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/clm104c23.pdf; 7) Medicare Claims Processing Manual: CMS Publication 100-04, Chapter 12, §40.7 – Claims for Bilateral Surgeries C. 3. (Effective 10/01/03) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf	Automated	9/24/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary; 7) 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8) National Coverage Determination Manual, Ch. 1, §220.6.13 FDG Positron Emission Tomography (PET) for Dementia and Neurodegenerative Diseases; Effective 09/04/2014; 9) Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; Effective 07/11/2017; 10) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.1- Billing Instructions, (D)- Post-Payment Review for PET Scans; Issued 04/02/2015; 11) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.12- Coverage for PET Scans for Dementia and Neurodegenerative Diseases; Effective 02/10/2017; 12) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; Effective 01/28/2015; 13) Novitas LCA A53134: Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions; Effective 10/01/2015; Revised 03/10/2016; 10/01/2016; 01/01/2017; 10/01/2017; 01/01/2018; 10/01/2018; 14) Noridian LCA A54666: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 07/01/2016; 10/01/2016; 01/01/2017; 04/01/2017; 10/01/2017; 12/15/2017; 1/1/2019; 15) Noridian LCA A54668: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 07/01/2016; 10/01/2016; 01/01/2017; 04/01/2017; 10/01/2017; 12/15/2017; 1/1/2019	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	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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary; 7) 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8) National Coverage Determination Manual, Ch. 1, §220.6.13 FDG Positron Emission Tomography (PET) for Dementia and Neurodegenerative Diseases; Effective 09/04/2014; 9) Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; Effective 07/11/2017; 10) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.1- Billing Instructions, (D)- Post-Payment Review for PET Scans; Issued 04/02/2015; 11) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.12- Coverage for PET Scans for Dementia and Neurodegenerative Diseases; Effective 02/10/2017; 12) Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; Effective 01/28/2015; 13) Novitas LCA A53134: Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions; Effective 10/01/2015; Revised 03/10/2016; 10/01/2016; 01/01/2017; 10/01/2017; 01/01/2018; 10/01/2018; 14) Noridian LCA A54666: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 07/01/2016; 10/01/2016; 01/01/2017; 04/01/2017; 10/01/2017; 12/15/2017; 1/1/2019; 15) Noridian LCA A54668: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 07/01/2016; 10/01/2016; 01/01/2017; 04/01/2017; 10/01/2017; 12/15/2017; 1/1/2019	Complex	9/25/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Carriers do not receive the transportation payment for EKG Services provided by Portable X-ray Suppliers or any other entity.	0166 - Transportation Component by Portable Suppliers for Electrocardiogram 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 13- Radiological Services and Other Diagnostic Procedures, Section 90.3-Transportation Component (HCPCS Codes R0070 – R0076); Effective:01-01-2016	Automated	10/4/2019	Approved
Carriers do not receive the transportation payment for EKG Services provided by Portable X-ray Suppliers or any other entity.	0166 - Transportation Component by Portable Suppliers for Electrocardiogram 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 13- Radiological Services and Other Diagnostic Procedures, Section 90.3-Transportation Component (HCPCS Codes R0070 – R0076); Effective:01-01-2016	Automated	10/4/2019	Approved
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for 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.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Cauterizations Billed as Separate Procedures	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 §411.15(k)(1), Particular services excluded from coverage (k) Any services that are not reasonable and necessary for one of the following purposes: (1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 7) 42 Code of Federal Regulations §424.5(a)(6), Basic conditions (a) As a basis for Medicare payment, the following conditions must be met: (6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.; 8) CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 - General Exclusions from Coverage §20- services not reasonable and necessary; 9) CMS Pub. 100-08, Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, Section 3.2.3- Requesting Additional Documentation During Prepayment and Post payment Review	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 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.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Cauterizations Billed as Separate Procedures	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 §411.15(k)(1), Particular services excluded from coverage (k) Any services that are not reasonable and necessary for one of the following purposes: (1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 7) 42 Code of Federal Regulations §424.5(a)(6), Basic conditions (a) As a basis for Medicare payment, the following conditions must be met: (6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.; 8) CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 - General Exclusions from Coverage §20- services not reasonable and necessary; 9) CMS Pub. 100-08, Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, Section 3.2.3- Requesting Additional Documentation During Prepayment and Post payment Review	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.	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	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 3- Outpatient Services Treated as Inpatient Services, §40.3.B- Preadmission Diagnostic Services; 7) Medicare Claims Processing Manual, Chapter 3- Outpatient Services Treated as Inpatient Services, §40.3.D- Other Preadmission Services	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.	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 §405.980- 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- Outpatient Services Treated as Inpatient Services, §40.3.B- Preadmission Diagnostic Services; 7) Medicare Claims Processing Manual, Chapter 3- Outpatient Services Treated as Inpatient Services, §40.3.D- Other Preadmission Services	Automated	11/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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	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) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1834 - Special Payment Rules; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1842(p)(4)- Provisions Relating to the Administration of Part B; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions; 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 Part; 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 Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4 - Coding Determinations; 10) Medicare Benefit Policy Manual, Chapter 16 - General exclusion from coverage, §10 - General exclusions from coverage; 11) Medicare Benefit Policy Manual, Chapter 16 - General exclusion from coverage, §20 - Services not reasonable and necessary; 12) National Correct Coding Initiative Policy Manual, Chapter 1 - General Correct Coding Policies, §E- Modifiers and Modifier Indicators; 13) National Correct Coding Initiative Policy Manual, Chapter 5 - Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems; 14) National Correct Coding Initiative Policy Manual, Chapter 9 - Radiology Services; 15) First Coast LCD L36767 - Aortography and Peripheral Angiography; Effective 10/31/2016; Revised 10/01/2018; 16) Novitas LCD L35092 - Diagnostic Abdominal Aortography and Renal Angiography Effective date 10/01/2015; Revised 05/10/2018; 17) Annual American Medical Association CPT Manual; Surgery, Cardiovascular; Appendix L Vascular Families	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.	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, §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) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1834 - Special Payment Rules; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1842(p)(4)- Provisions Relating to the Administration of Part B; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions; 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 Part; 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 Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4 - Coding Determinations; 10) Medicare Benefit Policy Manual, Chapter 16 - General exclusion from coverage, §10 - General exclusions from coverage; 11) Medicare Benefit Policy Manual, Chapter 16 - General exclusion from coverage, §20 - Services not reasonable and necessary; 12) National Correct Coding Initiative Policy Manual, Chapter 1 - General Correct Coding Policies, §E- Modifiers and Modifier Indicators; 13) National Correct Coding Initiative Policy Manual, Chapter 5 - Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems; 14) National Correct Coding Initiative Policy Manual, Chapter 9 - Radiology Services; 15) First Coast LCD L36767 - Aortography and Peripheral Angiography; Effective 10/31/2016; Revised 10/01/2018; 16) Novitas LCD L35092 - Diagnostic Abdominal Aortography and Renal Angiography Effective date 10/01/2015; Revised 05/10/2018; 17) Annual American Medical Association CPT Manual; Surgery, Cardiovascular; Appendix L Vascular Families	Complex	11/19/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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, §50 Drugs and Biologicals; 7) National Coverage Determinations (NCD) Manual, Chapter 1 Coverage Determinations, §110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions; 8) 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; §80.9 Required Modifiers for ESAs Administered to Non-ESRD Patients; and §80.12 Claim Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy; 9) CGS Administrators, LLC, L34356, Erythropoiesis Stimulating Agents (ESA), Effective 10/01/2015; Revised 10/01/2018; 10) WPS LCD L34633 Erythropoiesis Stimulating Agents – Epoetin alfa, Darbepoetin alfa, Peginesatide. Effective 10/01/2015; Revised 11/01/2019; 11) FCSO LCD L36276 Erythropoiesis Stimulating Agents. Effective 01/01/2015; Revised10/29/2019	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	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, §50 Drugs and Biologicals; 7) National Coverage Determinations (NCD) Manual, Chapter 1 Coverage Determinations, §110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions; 8) 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; §80.9 Required Modifiers for ESAs Administered to Non-ESRD Patients; and §80.12 Claim Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy; 9) CGS Administrators, LLC, L34356, Erythropoiesis Stimulating Agents (ESA), Effective 10/01/2015; Revised 10/01/2018; 10) WPS LCD L34633 Erythropoiesis Stimulating Agents – Epoetin alfa, Darbepoetin alfa, Peginesatide. Effective 10/01/2015; Revised 11/01/2019; 11) FCSO LCD L36276 Erythropoiesis Stimulating Agents. Effective 01/01/2015; Revised10/29/2019	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 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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost.; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR 410.40- Coverage of ambulance services, (a) Definitions and (c) Levels of service.; 10) 42 CFR 410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis.; 11) 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 13) 42 CFR 424.36- Signature Requirements; 14) 42 CFR 414.605 Definitions; 15) 42 CFR 414.610 Basis of Payment; 16) 42 CFR 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) 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; 18) Medicare Program Integrity Manual; Chapter 3 - Verifying Potential Errors and Taking Corrective Actions; §3.3.2.4 - Signature Requirements; G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) and Ambulance Certification Statements; 2. Ambulance Certification Statement Signature Requirements; 19) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20) Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.4 – Additional Introductory Guidelines, §20.5 – Documentation Requirements, and §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21) Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22) Novitas LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/20105, Revised 10/01/2020; 23) ECSO, LCD L33383, Non-	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 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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost.; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR 410.40- Coverage of ambulance services, (a) Definitions and (c) Levels of service.; 10) 42 CFR 410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis.; 11) 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 13) 42 CFR 424.36- Signature Requirements; 14) 42 CFR 414.605 Definitions; 15) 42 CFR 414.610 Basis of Payment; 16) 42 CFR 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) 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; 18) Medicare Program Integrity Manual; Chapter 3 - Verifying Potential Errors and Taking Corrective Actions; §3.3.2.4 - Signature Requirements; G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) and Ambulance Certification Statements; 2. Ambulance Certification Statement Signature Requirements; 19) Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20) Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.4 – Additional Introductory Guidelines, §20.5 – Documentation Requirements, and §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21) Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22) Novitas LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/20105, Revised 10/01/2020; 23) ECSO, LCD L33383, Non-	Complex	1/22/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (HHH)-Annual Wellness Visit; 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 §§ 410.15 - Annual Wellness Visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 8) 42 CFR §§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage; 9) 42 CFR § 411.15 - Particular services excluded from coverage, (a) Routine physical checkups such as:(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, Initial Preventive Physical Examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) (k) Any services that are not reasonable and necessary for one of the following purpose: (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; 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 Benefit Policy Manual- Chapter 15- Covered Medical and Other Health Services, §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 12) Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 13) Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 100.1.1 Evaluation and Management (E/M) Services -(C) Exception for E/M Services Furnished in Certain Primary Care Centers; 14) Medicare Claims Processing Manual- Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit	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	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 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (HHH)-Annual Wellness Visit; 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 §§ 410.15 - Annual Wellness Visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 8) 42 CFR §§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage; 9) 42 CFR § 411.15 - Particular services excluded from coverage, (a) Routine physical checkups such as:(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, Initial Preventive Physical Examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) (k) Any services that are not reasonable and necessary for one of the following purpose: (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; 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 Benefit Policy Manual- Chapter 15- Covered Medical and Other Health Services, §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 12) Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 13) Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 100.1.1 Evaluation and Management (E/M) Services -(C) Exception for E/M Services Furnished in Certain Primary Care Centers; 14) Medicare Claims Processing Manual- Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit	Complex	1/23/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The focus of this issue is to target claims where the definition of the procedure code includes imaging and imaging was then unbundled.	0179 - Procedures that Include Imaging: 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 23- Fee Schedule Administration and Coding Requirements, §20.9- National Correct Coding Initiative (CCI); 7) American Medical Association (AMA), Current Procedural Terminology (CPT); 8) The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual), Chapter III Surgery: Integumentary System CPT Codes 10000-19999; Chapter IV Surgery: Musculoskeletal System CPT Codes 20000-29999; Chapter V Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems CPT Codes 30000-39999; Chapter VI Surgery: Digestive System CPT Codes 40000-49999; Chapter VII Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems CPT Codes 50000-59999 ; Chapter VIII Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000-69999	Automated	3/4/2020	Approved
The focus of this issue is to target claims where the definition of the procedure code includes imaging and imaging was then unbundled.	0179 - Procedures that Include Imaging: 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 23- Fee Schedule Administration and Coding Requirements, §20.9- National Correct Coding Initiative (CCI); 7) American Medical Association (AMA), Current Procedural Terminology (CPT); 8) The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual), Chapter III Surgery: Integumentary System CPT Codes 10000-19999; Chapter IV Surgery: Musculoskeletal System CPT Codes 20000-29999; Chapter V Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems CPT Codes 30000-39999; Chapter VI Surgery: Digestive System CPT Codes 40000-49999; Chapter VII Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems CPT Codes 50000-59999 ; Chapter VIII Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000-69999	Automated	3/4/2020	Approved
The focus of this issue is to target claims where there was an additional payment made for imaging due to incorrect coding. If the provider billed a procedure code where the definition of the code does not include ultrasound and then billed ultrasound, the service will be re-coded to the code that includes ultrasound and the ultrasound will then be denied.	0180 - Procedures that Include Ultrasound: 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 23- Fee Schedule Administration and Coding Requirements, §20.9- National Correct Coding Initiative (CCI); 7) American Medical Association (AMA), Current Procedural Terminology (CPT); 8) The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual)	Automated	2/20/2020	Approved
The focus of this issue is to target claims where there was an additional payment made for imaging due to incorrect coding. If the provider billed a procedure code where the definition of the code does not include ultrasound and then billed ultrasound, the service will be re-coded to the code that includes ultrasound and the ultrasound will then be denied.	0180 - Procedures that Include Ultrasound: 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 23- Fee Schedule Administration and Coding Requirements, §20.9- National Correct Coding Initiative (CCI); 7) American Medical Association (AMA), Current Procedural Terminology (CPT); 8) The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual)	Automated	2/20/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The medical record will be reviewed to determine if the service was reasonable and necessary and all documentation requirements are present for MS-DRGs: 009 - Bone marrow transplant, 014 - Allogenic bone marrow transplant, 016 - Autologous bone marrow transplant with a complication or comorbidity (CC), 017 - Autologous bone marrow transplant without a CC or major CC.	0181 - Inpatient Bone Marrow & Stem Cell Transplant: Medical Necessity and Documentation Requirements	Inpatient Hospital	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, § 3.6.2.1- Coverage determinations, §3.6.2.2-Reasonable and Necessary Criteria, §3.4.1.3-Diagnosis Code Requirements, §3.3.2.4-Signature Requirements; 6) National Coverage Determination Manual, Chapter 1, Part 2- Coverage Determinations, §110.23- Stem Cell Transplantation	Complex	3/19/2020	Approved
The medical record will be reviewed to determine if the service was reasonable and necessary and all documentation requirements are present for MS-DRGs: 009 - Bone marrow transplant, 014 - Allogenic bone marrow transplant, 016 - Autologous bone marrow transplant with a complication or comorbidity (CC), 017 - Autologous bone marrow transplant without a CC or major CC.	0181 - Inpatient Bone Marrow & Stem Cell Transplant: 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 §405.980- 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, § 3.6.2.1- Coverage determinations, §3.6.2.2-Reasonable and Necessary Criteria, §3.4.1.3-Diagnosis Code Requirements, §3.3.2.4-Signature Requirements; 6) National Coverage Determination Manual, Chapter 1, Part 2- Coverage Determinations, §110.23- Stem Cell Transplantation	Complex	3/19/2020	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 of Diagnostic Cardiovascular Services	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 23, §30.2- Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf Note: Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html; 7) CMS Transmittal 1149 – Change Request 7848 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf; 8) Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction CY 2019 downloads https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU19A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending; 9) PFS (Physician Fee Schedule) Relative Value Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	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 of 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; 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 23, §30.2- Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf Note: Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html; 7) CMS Transmittal 1149 – Change Request 7848 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf; 8) Diagnostic Cardiovascular Services Subject to The Multiple Procedure Payment Reduction CY 2019 downloads https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU19A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending; 9) PFS (Physician Fee Schedule) Relative Value Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	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.	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	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) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost.; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l)(10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service.; 10) 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis.; 11) 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §414.605 Definitions; 13) 42 CFR §414.610 Basis of Payment; 14) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 15) 42 CFR §424.36- Signature Requirements; 16) 42 CFR §424.37- Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) Federal Register 62861; Vol. 84, No. 221; Rules and Regulations Other Provisions of the Proposed Regulations A. Changes to the Ambulance Physician Certification Statement Requirement; 18) 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; 19) Medicare Benefit Policy Manual (MBPM), Chapter 10 Ambulance Services (Rev. 1, 10-01-03); §10 Ambulance Service; §20 Coverage Guidelines for Ambulance Service Claims (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-2009; Implementation Date: 03-20-09); §30.1.1 Ground Ambulance Services (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09); 20) Medicare Claims Processing Manual, Chapter 15 Ambulance, §30 General Billing Guidelines, (A) Modifiers Specific to Ambulance Service Claims and (B) HCPCS Codes (Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14) ; 21) Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.15.2	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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.	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.; 3) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost.; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l)(10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service.; 10) 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis.; 11) 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §414.605 Definitions; 13) 42 CFR §414.610 Basis of Payment; 14) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 15) 42 CFR §424.36- Signature Requirements; 16) 42 CFR §424.37- Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) Federal Register 62861; Vol. 84, No. 221; Rules and Regulations Other Provisions of the Proposed Regulations A. Changes to the Ambulance Physician Certification Statement Requirement; 18) 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; 19) Medicare Benefit Policy Manual (MBPM), Chapter 10 Ambulance Services (Rev. 1, 10-01-03); §10 Ambulance Service; §20 Coverage Guidelines for Ambulance Service Claims (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-2009; Implementation Date: 03-20-09); §30.1.1 Ground Ambulance Services (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09); 20) Medicare Claims Processing Manual, Chapter 15 Ambulance, §30 General Billing Guidelines, (A) Modifiers Specific to Ambulance Service Claims and (B) HCPCS Codes (Issued: 09-24-14, Effective: Upon Implementation of ICD-10 ASC X12: 01-01-12, Implementation: ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14).; 21) Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.15.2	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	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 §482.24 - Condition of participation: Medical record services; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provision in an LCD; 11) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13) First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14) First Coast LCA A57765, Billing and Coding: Total Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 02/18/2020; 15) First Coast LCA A5589, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018.; 16) First Coast LCA A5589, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018.; 17) Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 18) Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 19) NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 11/14/2019; 20) NGS LCA A57428, Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 21) Palmetto LCD L33456-Total Joint ARTHROPLASTY; Effective 10/01/2015; Revised 10/24/2019; 22) Palmetto LCA A56777- Billing and Coding: Total Joint ARTHROPLASTY; Effective 08/01/2019; Revised 10/17/2019; 23) Noridian LCD L36573- Total Hip Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 24) Noridian LCA A57684	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 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	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 §482.24 - Condition of participation: Medical record services; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provision in an LCD; 11) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13) First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14) First Coast LCA A57765, Billing and Coding: Total Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 02/18/2020; 15) First Coast LCA A5589, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018.; 16) First Coast LCA A5589, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018.; 17) Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 18) Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 19) NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 11/14/2019; 20) NGS LCA A57428, Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 21) Palmetto LCD L33456-Total Joint ARTHROPLASTY; Effective 10/01/2015; Revised 10/24/2019; 22) Palmetto LCA A56777- Billing and Coding: Total Joint ARTHROPLASTY; Effective 08/01/2019; Revised 10/17/2019; 23) Noridian LCD L36573- Total Hip Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 24) Noridian LCA A57684	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	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 §482.24 - Condition of participation: Medical record services; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4-Reasonable and Necessary Provision in an LCD; 11) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13) First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14) First Coast LCA A55899, Billing and Coding: Total Joint Replacement (Hip and Knee); Effective 10/03/2018; 15) First Coast LCA A56153, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018; 16) Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 17) Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 18) NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 11/14/2019; 19) NGS LCA A57428, Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 20) Palmetto LCD L33456-Total Joint ARTHROPLASTY; Effective 10/01/2015; Revised 10/24/2019; 21) Palmetto LCA A56777- Billing and Coding: Total Joint ARTHROPLASTY; Effective 08/01/2019; Revised 10/17/2019; 22) Noridian LCD L36575- Total Knee Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 23) Noridian LCA A57685- Billing and Coding: Total Knee Arthroplasty; Effective 12/01/2019; 24) Noridian LCD L36577- Total Knee Arthroplasty; Effective 09/07/2016; Revised 12/01/2019;	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	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 §482.24 - Condition of participation: Medical record services; 5) 42 CFR §405.986- Good Cause for Reopening; 6) Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7) Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 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 Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10) Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4-Reasonable and Necessary Provision in an LCD; 11) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13) First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14) First Coast LCA A55899, Billing and Coding: Total Joint Replacement (Hip and Knee); Effective 10/03/2018; 15) First Coast LCA A56153, Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018; 16) Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 17) Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 18) NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 11/14/2019; 19) NGS LCA A57428, Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 20) Palmetto LCD L33456-Total Joint ARTHROPLASTY; Effective 10/01/2015; Revised 10/24/2019; 21) Palmetto LCA A56777- Billing and Coding: Total Joint ARTHROPLASTY; Effective 08/01/2019; Revised 10/17/2019; 22) Noridian LCD L36575- Total Knee Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 23) Noridian LCA A57685- Billing and Coding: Total Knee Arthroplasty; Effective 12/01/2019; 24) Noridian LCD L36577- Total Knee Arthroplasty; Effective 09/07/2016; Revised 12/01/2019;	Complex	8/3/2020	Approved
This review will determine if a duplex scan of the extracranial arteries 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	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 §410.32(a)- Ordering Diagnostic Tests; 6) 42 CFR §410.32(b)- Diagnostic x-ray and other diagnostic tests; 7) 42 CFR §410.33- Independent Diagnostic Testing Facility; 8) National Coverage Determinations Manual, Chapter 1, Part 1, §20.17- Noninvasive Tests of Carotid Function; 9) National Coverage Determinations Manual, Chapter 1, Part 4, §220.5- Ultrasound Diagnostic Procedures; 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 Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §10.1 - Billing Part B Radiology Services and Other Diagnostic Procedures; 12) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; 13) CGS LCD L34045: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 11/28/2019; 14) First Coast LCD L33695: Non-Invasive Extracranial Arterial Studies; Effective 10/01/2015; Revised 01/08/2019; 15) NGS LCD L33627: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/01/2019; 16) Noridian LCD L34221: Noninvasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/01/2019; 17) Novitas LCD L35397: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 10/17/2019; 18) WPS LCD L35753: Non-Invasive Cerebrovascular Studies; Effective 10/01/2015; Revised 12/26/2019; 19) CGS LCA A56697: Billing and Coding: Non-Invasive Vascular Studies; Effective 07/11/2019; Revised 01/01/2020; 20) First Coast LCA A57670: Billing and Coding: Non-Invasive Extracranial Arterial Studies; Effective 10/03/2018; 21) NGS LCA A56758: Billing and Coding: Non-Invasive Vascular Studies; Effective 08/01/2019; Revised 01/01/2020; 22) Noridian LCA A57199: Billing and Coding: Noninvasive Cerebrovascular Studies; Effective 10/01/2019; 23) Novitas LCA A52992: Billing and Coding: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 8/02/2019; 24) WPS LCA A57592: Billing and Coding: Non-Invasive Cerebrovascular Studies; Effective 11/01/2019	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This review will determine if a duplex scan of the extracranial arteries 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; 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 §410.32(a)- Ordering Diagnostic Tests; 6) 42 CFR §410.32(b)- Diagnostic x-ray and other diagnostic tests; 7) 42 CFR §410.33- Independent Diagnostic Testing Facility; 8) National Coverage Determinations Manual, Chapter 1, Part 1, §20.17- Noninvasive Tests of Carotid Function; 9) National Coverage Determinations Manual, Chapter 1, Part 4, §220.5- Ultrasound Diagnostic Procedures; 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 Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §10.1 - Billing Part B Radiology Services and Other Diagnostic Procedures; 12) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; 13) CGS LCD L34045: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 11/28/2019; 14) First Coast LCD L33695: Non-Invasive Extracranial Arterial Studies; Effective 10/01/2015; Revised 01/08/2019; 15) NGS LCD L33627: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/01/2019; 16) Noridian LCD L34221: Noninvasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/01/2019; 17) Novitas LCD L35397: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 10/17/2019; 18) WPS LCD L35753: Non-Invasive Cerebrovascular Studies; Effective 10/01/2015; Revised 12/26/2019; 19) CGS LCA A56697: Billing and Coding: Non-Invasive Vascular Studies; Effective 07/11/2019; Revised 01/01/2020; 20) First Coast LCA A57670: Billing and Coding: Non-Invasive Extracranial Arterial Studies; Effective 10/03/2018; 21) NGS LCA A56758: Billing and Coding: Non-Invasive Vascular Studies; Effective 08/01/2019; Revised 01/01/2020; 22) Noridian LCA A57199: Billing and Coding: Noninvasive Cerebrovascular Studies; Effective 10/01/2019; 23) Novitas LCA A52992: Billing and Coding: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 8/02/2019; 24) WPS LCA A57592: Billing and Coding: Non-Invasive Cerebrovascular Studies; Effective 11/01/2019	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	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 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 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) 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7) Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.23- Sensory Nerve Conduction Threshold Tests (sNCTs); 8) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Effective 01/01/2019; 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) CGS, Local Coverage Determination L35897- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/24/2019; 11) First Coast Local Coverage Determination L34859- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/01/2019; 12) NGS, Local Coverage Determination L35098- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 11/21/2019; 13) Noridian Healthcare Solutions, LLC, Local Coverage Determination L36524- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 12/01/2019; 14) Noridian Healthcare Solutions, LLC, Local Coverage Determination L36526- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 12/01/2019; 15) Novitas Solutions, Inc., Local Coverage Determination L35081- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 16) Palmetto GBA Local Coverage Determination L35048- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/10/2019; 17) WPS Local Coverage Determination L34594- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 18) CGS, Local Coverage Article A57307- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 9/26/2019; Revised 10/24/2019; 19) First Coast Local Coverage Article A57123- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 10/03/2018; 20) First Coast Local Coverage Article A56035- Nerve Conduction Studies and Electromyography- Revision to the Part A and Part B LCD; Effective: 5/31/2018; 21) NGS, Local Coverage Article A57668- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 11/21/2019; 22) Noridian Healthcare Solutions, LLC, Local Coverage Article A54969-	Complex	9/25/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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; 3) 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 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) 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7) Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.23- Sensory Nerve Conduction Threshold Tests (sNCTs); 8) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Effective 01/01/2019; 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) CGS, Local Coverage Determination L35897- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/24/2019; 11) First Coast Local Coverage Determination L34859- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/01/2019; 12) NGS, Local Coverage Determination L35098- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 11/21/2019; 13) Noridian Healthcare Solutions, LLC, Local Coverage Determination L36524- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 12/01/2019; 14) Noridian Healthcare Solutions, LLC, Local Coverage Determination L36526- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 12/01/2019; 15) Novitas Solutions, Inc., Local Coverage Determination L35081- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 16) Palmetto GBA Local Coverage Determination L35048- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/10/2019; 17) WPS Local Coverage Determination L34594- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 18) CGS, Local Coverage Article A57307- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 9/26/2019; Revised 10/24/2019; 19) First Coast Local Coverage Article A57123- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 10/03/2018; 20) First Coast Local Coverage Article A56035- Nerve Conduction Studies and Electromyography- Revision to the Part A and Part B LCD; Effective: 5/31/2018; 21) NGS, Local Coverage Article A57668- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 11/21/2019; 22) Noridian Healthcare Solutions, LLC, Local Coverage Article A54969-	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	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 Determination Manual, Chapter 1, Part 4, §240.4.1- Sleep Testing for Obstructive Sleep Apnea (OSA); 6) 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §70- Sleep Disorder Clinics; 8) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests; 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) CGS Administrators, LLC, LCD L36902- Polysomnography and Other Sleep Studies; Effective 3/6/2017; Revised 9/26/2019; 11) First Coast Service Options, Inc., LCD L33405- Polysomnography and Sleep Testing; Effective 10/01/2015; Revised 7/01/2020; 12) Noridian Healthcare Solutions, LLC, LCD L34040- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Revised 12/01/2019; 13) Noridian Healthcare Solutions, LLC, LCD L36861- Polysomnography and Other Sleep Studies; Effective 06/05/2017; Revised 12/01/2019; 14) Novitas Solutions, Inc., LCD L35050- Outpatient Sleep Studies; Effective 10/01/2015; Revised 9/12/2019; 15) Palmetto GBA, LCD L36593- Polysomnography; Effective 6/13/2016; Revised 10/24/2019 16) WPS, LCD L36839- Polysomnography and Other Sleep Studies; Effective 2/16/2017; Revised 11/01/2019; 17) CGS Administrators, LCA A57049- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 9/26/2019; Revised 01/24/2020; 18) First Coast Service Options, Inc., LCA A57496- Billing and Coding: Polysomnography and Sleep Testing; Effective 10/03/2018; Revised 7/01/2020; 19) National Government Services, Inc., LCA A53019- Polysomnography and Sleep Studies- Medical Policy Article; Effective 10/01/2015; Revised 10/31/2019; 20) Noridian Healthcare Solutions, LLC, LCA A57698- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 21) Noridian Healthcare Solutions, LLC, LCA A55307- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Retired 5/14/2020; 22) Noridian Healthcare Solutions, LLC, LCA A55308- Polysomnography and	Complex	9/24/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 Determination Manual, Chapter 1, Part 4, §240.4.1- Sleep Testing for Obstructive Sleep Apnea (OSA); 6) 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §70- Sleep Disorder Clinics; 8) Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests; 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) CGS Administrators, LLC, LCD L36902- Polysomnography and Other Sleep Studies; Effective 3/6/2017; Revised 9/26/2019; 11) First Coast Service Options, Inc., LCD L33405- Polysomnography and Sleep Testing; Effective 10/01/2015; Revised 7/01/2020; 12) Noridian Healthcare Solutions, LLC, LCD L34040- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Revised 12/01/2019; 13) Noridian Healthcare Solutions, LLC, LCD L36861- Polysomnography and Other Sleep Studies; Effective 06/05/2017; Revised 12/01/2019; 14) Novitas Solutions, Inc., LCD L35050- Outpatient Sleep Studies; Effective 10/01/2015; Revised 9/12/2019; 15) Palmetto GBA, LCD L36593- Polysomnography; Effective 6/13/2016; Revised 10/24/2019 16) WPS, LCD L36839- Polysomnography and Other Sleep Studies; Effective 2/16/2017; Revised 11/01/2019; 17) CGS Administrators, LCA A57049- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 9/26/2019; Revised 01/24/2020; 18) First Coast Service Options, Inc., LCA A57496- Billing and Coding: Polysomnography and Sleep Testing; Effective 10/03/2018; Revised 7/01/2020; 19) National Government Services, Inc., LCA A53019- Polysomnography and Sleep Studies- Medical Policy Article; Effective 10/01/2015; Revised 10/31/2019; 20) Noridian Healthcare Solutions, LLC, LCA A57698- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 21) Noridian Healthcare Solutions, LLC, LCA A55307- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Retired 5/14/2020; 22) Noridian Healthcare Solutions, LLC, LCA A55308- Polysomnography and	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 determine if a left ventricular assist device (LVAD) was placed for a Medicare covered indication. All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials or as a routine cost in clinical trials.	0192 - Ventricular Assist Device: Medical Necessity	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 1833(e) - Payment of Benefits; 2) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); 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 §121.1-121.13-Organ Procurement and Transplantation Network; 6) Medicare National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §20.9.1 - Ventricular Assist Devices; 7) Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 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) Palmetto GBA A53988 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 10/10/2019; 10) Palmetto GBA A53986 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 10/03/2019; 11) Annual American Medical Association: CPT Manual; 12) CMS ICD-10 Procedure Coding System	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. All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials or as a routine cost in clinical trials.	0192 - Ventricular Assist Device: Medical Necessity	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); 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 §121.1-121.13-Organ Procurement and Transplantation Network; 6) Medicare National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §20.9.1 - Ventricular Assist Devices; 7) Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 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) Palmetto GBA A53988 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 10/10/2019; 10) Palmetto GBA A53986 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 10/03/2019; 11) Annual American Medical Association: CPT Manual; 12) CMS ICD-10 Procedure Coding System	Complex	9/25/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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. Claims for skin substitute products billed with excessive or insufficient units will be reviewed by a nurse, pharmacist, certified pharmacy technician, or certified coder to determine the actual	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	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 CFR § 419.2(b)(16) – Centers for Medicare & Medicaid Services, HHS, (§ 419) Basis of payment, (16) drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals); 7) Medicare Claims Processing Manual, Ch. 17, §§10, 40, 70 and 90.2 – (10) Payment Rules for Drugs and Biologicals, (40) Discarded Drugs and Biologicals, (70) Claims Processing Requirements- General, (90.2) Drugs, Biologicals, and Radiopharmaceuticals; 8) Medicare Alpha-Numeric HCPCS File – Alpha-Numeric HCPCS, Centers for Medicare & Medicaid Services; 9) Annual HCPCS Level II Manual - Centers for Medicare & Medicaid Services	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. Claims for skin substitute products billed with excessive or insufficient units will be reviewed by a nurse, pharmacist, certified pharmacy technician, or certified coder to determine the actual	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	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 CFR § 419.2(b)(16) – Centers for Medicare & Medicaid Services, HHS, (§ 419) Basis of payment, (16) drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals); 7) Medicare Claims Processing Manual, Ch. 17, §§10, 40, 70 and 90.2 – (10) Payment Rules for Drugs and Biologicals, (40) Discarded Drugs and Biologicals, (70) Claims Processing Requirements- General, (90.2) Drugs, Biologicals, and Radiopharmaceuticals; 8) Medicare Alpha-Numeric HCPCS File – Alpha-Numeric HCPCS, Centers for Medicare & Medicaid Services; 9) Annual HCPCS Level II Manual - Centers for Medicare & Medicaid Services	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: Coverage with Evidence Development and Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR 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 1862(a)(1)(E)-Exclusions from Coverage and Medicare as a Secondary Payer; 3) SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 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 National Coverage Determination (NCD) Manual, Chapter 1- Coverage Determinations, §20.8.4-Leadless Pacemakers, §310.1- Routine Costs in Clinical Trials; 7) Medicare Claims Processing Manual, Chapter 32-Billing Requirements for Special Services, §380-Leadless Pacemakers, §380.1-Leadless Pacemaker Coding and Billing Requirements for Professional Claims, §380.1.2-Leadless Pacemaker Modifier, §380.1.3-Leadless Pacemaker Additional Claim Billing Information; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §69-Qualifying Clinical Trails-General, §69.1 -General, §69.2-Payment for Qualifying Clinical Trial Services, §69.3 - Medical Records Documentation Requirements, §69.5 -Billing Requirements – General, §69.6-Requirements for Billing Routine Costs of Clinical Trials; 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, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 10) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.4- Review of Procedures Affecting the DRG; 11) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 12) Novitas Solutions, Inc., LCD L35094-Services That Are Not Reasonable and Necessary, Effective 10/01/2015, Revised 03/15/2020, Retired 7/1/20; 13) Annual American Medical Association (AMA) CPT Manual; 14) Annual ICD-10-CM Manual; 15) Annual ICD-10-PCS Manual	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: Coverage with Evidence Development and Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	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 1862(a)(1)(E)-Exclusions from Coverage and Medicare as a Secondary Payer; 3) SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 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 National Coverage Determination (NCD) Manual, Chapter 1- Coverage Determinations, §20.8.4-Leadless Pacemakers, §310.1- Routine Costs in Clinical Trials; 7) Medicare Claims Processing Manual, Chapter 32-Billing Requirements for Special Services, §380-Leadless Pacemakers, §380.1-Leadless Pacemaker Coding and Billing Requirements for Professional Claims, §380.1.2-Leadless Pacemaker Modifier, §380.1.3-Leadless Pacemaker Additional Claim Billing Information; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §69-Qualifying Clinical Trails-General, §69.1 -General, §69.2-Payment for Qualifying Clinical Trial Services, §69.3 - Medical Records Documentation Requirements, §69.5 -Billing Requirements – General, §69.6-Requirements for Billing Routine Costs of Clinical Trials; 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, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 10) Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.4- Review of Procedures Affecting the DRG; 11) Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 12) Novitas Solutions, Inc., LCD L35094-Services That Are Not Reasonable and Necessary, Effective 10/01/2015, Revised 03/15/2020, Retired 7/1/20; 13) Annual American Medical Association (AMA) CPT Manual; 14) Annual ICD-10-CM Manual; 15) Annual ICD-10-PCS Manual	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 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	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) Manual: Chapter 1 – Coverage Determinations, Part 1- Sections 10- 80.12, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 9) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 10) First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 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 10/01/2019; 13) Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 14) Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 4/9/2020; 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 3/26/2020	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	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) Manual: Chapter 1 – Coverage Determinations, Part 1- Sections 10- 80.12, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 8) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 9) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 10) First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 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 10/01/2019; 13) Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 14) Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 4/9/2020; 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 3/26/2020	Complex	10/23/2020	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	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, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.3- Healthcare Common Procedure Coding System (HCPCS); 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	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 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	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, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.3- Healthcare Common Procedure Coding System (HCPCS); 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	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	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, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	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	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, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; 7) Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	Complex	11/18/2020	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 a distal claviculectomy was performed.	0199 - Distal Claviculectomy: Incorrect Coding	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) American Medical Association, CPT® Changes 2002: An Insider's View; 7) National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	Complex	11/21/2020	Approved
Documentation will be reviewed to determine if a distal claviculectomy was performed.	0199 - Distal Claviculectomy: 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 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) American Medical Association, CPT® Changes 2002: An Insider's View; 7) National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l)(10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service.; 10) 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis.; 11) 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §414.605 Definitions; 13) 42 CFR §414.610 Basis of Payment; 14) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 15) 42 CFR §424.36- Signature Requirements; 16) 42 CFR §424.37- Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) Federal Register 62861; Vol. 84, No. 221; Rules and Regulations Other Provisions of the Proposed Regulations A. Changes to the Ambulance Physician Certification Statement Requirement *only applies to Delaware, Maryland, NJ, NC, PA, SC, VA, and WV*; 18) 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; 19) Medicare Benefit Policy Manual (MBPM), Chapter 10, Ambulance Services, §10.4 Air Ambulance Services (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20- 09); 20) Medicare Claims Processing Manual, Chapter 15, Payment Rules, §20.3, Air Ambulance (Rev.3380, Issued: 10-23-15, Effective: 01-01-16, Implementation: 01-04-16); 21) Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.15.2 Emergencies or Urgent Situations/Ambulance Transport (Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)	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	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(s)(7)- Definitions of Services, Institutions, Etc.; 4) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5) Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l)(10)-(16)- Establishment of Fee Schedule for Ambulance 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) 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9) 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service.; 10) 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis.; 11) 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements.; 12) 42 CFR §414.605 Definitions; 13) 42 CFR §414.610 Basis of Payment; 14) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary.; 15) 42 CFR §424.36- Signature Requirements; 16) 42 CFR §424.37- Evidence of Authority to Sign In on behalf of the Beneficiary.; 17) Federal Register 62861; Vol. 84, No. 221; Rules and Regulations Other Provisions of the Proposed Regulations A. Changes to the Ambulance Physician Certification Statement Requirement *only applies to Delaware, Maryland, NJ, NC, PA, SC, VA, and WV*; 18) 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; 19) Medicare Benefit Policy Manual (MBPM), Chapter 10, Ambulance Services, §10.4 Air Ambulance Services (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20- 09); 20) Medicare Claims Processing Manual, Chapter 15, Payment Rules, §20.3, Air Ambulance (Rev.3380, Issued: 10-23-15, Effective: 01-01-16, Implementation: 01-04-16); 21) Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.15.2 Emergencies or Urgent Situations/Ambulance Transport (Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)	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.	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	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 CFR § 409.27(c) – Other services generally provided by (or under arrangements made by) SNF; 7) General Explanation of the Major Categories I. – V. for Skilled Nursing Facility (SNF) Consolidated Billing – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index; 8) Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1 - Ambulance Services, Effective 6-19-18	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.	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; 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 CFR § 409.27(c) – Other services generally provided by (or under arrangements made by) SNF; 7) General Explanation of the Major Categories I. – V. for Skilled Nursing Facility (SNF) Consolidated Billing – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index; 8) Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1 - Ambulance Services, Effective 6-19-18	Automated	2/4/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 Surgery	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, §50 – Payment for Anesthesiology Services – Effective 01/01/2017 and §140.3.2 – Anesthesia Time and Calculation of Anesthesia Time Units Effective 01/01/2017 AND §104.3.3 – Billing Modifiers - Effective 01/01/2017; 7) CMS Anesthesiologists Center – Anesthesia Conversion Factors- https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html	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 Surgery	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, §50 – Payment for Anesthesiology Services – Effective 01/01/2017 and §140.3.2 – Anesthesia Time and Calculation of Anesthesia Time Units Effective 01/01/2017 AND §104.3.3 – Billing Modifiers - Effective 01/01/2017; 7) CMS Anesthesiologists Center – Anesthesia Conversion Factors- https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html	Automated	3/3/2021	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 reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed. VNS is reasonable and necessary for treatment resistant depression through Coverage with Evidence Development. VNS for treatment of resistant depression is non-covered when furnished outside of a CMS-approved CED study. Medical documentation will be reviewed to determine that services were medically reasonable and necessary and a covered benefit.	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	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 (NCD) Manual, Chapter 1, Part 2, 160.18- Vagus Nerve Stimulation (VNS); 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §200- Billing Requirements for Vagus Nerve Stimulation (VNS); 8) Annual American Medical Association: CPT Manual; 9) CMS ICD-10 Procedure Coding System	Complex	3/11/2021	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 reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed. VNS is reasonable and necessary for treatment resistant depression through Coverage with Evidence Development. VNS for treatment of resistant depression is non-covered when furnished outside of a CMS-approved CED study. Medical documentation will be reviewed to determine that services were medically reasonable and necessary and a covered benefit.	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	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 (NCD) Manual, Chapter 1, Part 2, 160.18- Vagus Nerve Stimulation (VNS); 7) Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §200- Billing Requirements for Vagus Nerve Stimulation (VNS); 8) Annual American Medical Association: CPT Manual; 9) CMS ICD-10 Procedure Coding System	Complex	3/11/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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 §405.986-Good Cause for Reopening; 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 § 410.28-Hospital or CAH diagnostic services furnished to outpatients: Conditions; 6) 42 CFR §410.32-Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions, (a)-Ordering diagnostic tests; 7) 42 CFR §424.5(a)(6)-Sufficient information; 8) 42 CFR §493-Laboratory Requirements, §493.1 Basis and scope; 9) 45 CFR §162.1002(c)-Medical data code sets, for the period on and after October 1, 2015; 10) Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, §80.1 – Clinical Laboratory Services; 11) Medicare Benefit Policy Manual, Chapter 16-General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12) Medicare Claims Processing Manual, Chapter 16- Laboratory Services,§40.7 Billing for Noncovered Clinical Laboratory Tests Section; 13) Medicare Claims Processing Manual, Chapter 30- Financial Liability Protections, §50- Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN), §120.1 - Documentation of Notices Regarding Coverage; 14) 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, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 15) Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2- Coverage Determinations, §90.2-Next Generation Sequencing for Patients with Advanced Cancer; (Rev. 215, Issued: 04-10-19, Effective: 01/27/2020, Implementation: 11/13/2020); 16) Annual American Medical Association (AMA) CPT Manual; 17) Annual ICD-10-CM Manual	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	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 §405.986-Good Cause for Reopening; 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 § 410.28-Hospital or CAH diagnostic services furnished to outpatients: Conditions; 6) 42 CFR §410.32-Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions, (a)-Ordering diagnostic tests; 7) 42 CFR §424.5(a)(6)-Sufficient information; 8) 42 CFR §493-Laboratory Requirements, §493.1 Basis and scope; 9) 45 CFR §162.1002(c)-Medical data code sets, for the period on and after October 1, 2015; 10) Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, §80.1 – Clinical Laboratory Services; 11) Medicare Benefit Policy Manual, Chapter 16-General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12) Medicare Claims Processing Manual, Chapter 16- Laboratory Services,§40.7 Billing for Noncovered Clinical Laboratory Tests Section; 13) Medicare Claims Processing Manual, Chapter 30- Financial Liability Protections, §50- Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN), §120.1 - Documentation of Notices Regarding Coverage; 14) 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, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 15) Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2- Coverage Determinations, §90.2-Next Generation Sequencing for Patients with Advanced Cancer; (Rev. 215, Issued: 04-10-19, Effective: 01/27/2020, Implementation: 11/13/2020); 16) Annual American Medical Association (AMA) CPT Manual; 17) Annual ICD-10-CM Manual	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	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; 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 §424.5 - Basic Conditions, (a)(6) - Sufficient Information; 6) 42 CFR §411.15 - Particular Services Excluded from Coverage, (k) - Any Services Not Reasonable and Necessary; 7) 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8) National Coverage Determination Manual, Ch. 1, §220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions; 9) Medicare Program Integrity Manual, Ch. 3 - Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 10) Medicare Claims Processing Manual, Ch. 13 - Radiology Services and Other Diagnostic Procedures, §60 - General Information; §60.1 - Billing Instructions, (D)- Post-Payment Review for PET Scans; §60.3.1 - Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; §60.3.2 - Tracer Codes Required for Positron Emission Tomography (PET) Scans; and §60.7 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009; 11) Noridian LCA 54666: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Ending date 03/31/2021; 12) Noridian LCA 54668: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Revised date 4/1/2021; 13) Novitas LCA A53132: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 10/1/2015; Revised date 11/21/2019	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	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; 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 §424.5 - Basic Conditions, (a)(6) - Sufficient Information; 6) 42 CFR §411.15 - Particular Services Excluded from Coverage, (k) - Any Services Not Reasonable and Necessary; 7) 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8) National Coverage Determination Manual, Ch. 1, §220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions; 9) Medicare Program Integrity Manual, Ch. 3 - Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 10) Medicare Claims Processing Manual, Ch. 13 - Radiology Services and Other Diagnostic Procedures, §60 - General Information; §60.1 - Billing Instructions, (D)- Post-Payment Review for PET Scans; §60.3.1 - Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; §60.3.2 - Tracer Codes Required for Positron Emission Tomography (PET) Scans; and §60.7 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009; 11) Noridian LCA 54666: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Ending date 03/31/2021; 12) Noridian LCA 54668: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Revised date 4/1/2021; 13) Novitas LCA A53132: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 10/1/2015; Revised date 11/21/2019	Complex	5/29/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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; 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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 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) Medicare National Coverage Determination Manual, Chapter 1, §160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation and §160.7 Electrical Nerve Stimulators, (B) Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators); 9) Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, §13.5.4 Reasonable and Necessary Provision in an LCD; 10) First Coast Local Coverage Determination L36035- Spinal Cord Stimulation for Chronic Pain; Effective 10/01/2015; Revised 11/28/2019; 11) First Coast Local Coverage Article A57709- Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 10/03/2018; 12) Novitas Local Coverage Determination L35450- Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 10/01/2015; Revised 09/26/2019; 13) Novitas Local Coverage Article A57023- Billing and Coding: Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 09/26/2019; Revised 09/26/2019; 14) Palmetto Local Coverage Determination L37632- Spinal Cord Stimulators for Chronic Pain; Effective 01/29/2018; Revised 10/24/2019; 15) Palmetto Local Coverage Article A56876- Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 08/22/2019; Revised 10/17/2019; 16) Cahaba Government Benefit Administrators L36879 – Surgery: Spinal Cord Stimulators for Chronic Pain; Effective 03/01/2017; Retired 02/25/2018; 17) Noridian Local Coverage Determination L36204- Spinal Cord Stimulators for Chronic Pain; Effective 06/01/2016; Revised 12/01/2019; 18) Noridian Local Coverage Determination L35136 – Spinal Cord Stimulators for Chronic Pain; Effective 10/01/2015; Revised 12/01/2019; 19) Noridian Local Coverage Article A57791 – Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 12/01/2019; 20) American Hospital Association (AHA) Coding Clinic for HCPCS; 21) American Medical Association (AMA) Current Procedure Terminology Assistant; 22) National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VIII – Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory	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	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; 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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6) 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 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) Medicare National Coverage Determination Manual, Chapter 1, §160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation and §160.7 Electrical Nerve Stimulators, (B) Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators); 9) Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, §13.5.4 Reasonable and Necessary Provision in an LCD; 10) First Coast Local Coverage Determination L36035- Spinal Cord Stimulation for Chronic Pain; Effective 10/01/2015; Revised 11/28/2019; 11) First Coast Local Coverage Article A57709- Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 10/03/2018; 12) Novitas Local Coverage Determination L35450- Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 10/01/2015; Revised 09/26/2019; 13) Novitas Local Coverage Article A57023- Billing and Coding: Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 09/26/2019; Revised 09/26/2019; 14) Palmetto Local Coverage Determination L37632- Spinal Cord Stimulators for Chronic Pain; Effective 01/29/2018; Revised 10/24/2019; 15) Palmetto Local Coverage Article A56876- Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 08/22/2019; Revised 10/17/2019; 16) Cahaba Government Benefit Administrators L36879 – Surgery: Spinal Cord Stimulators for Chronic Pain; Effective 03/01/2017; Retired 02/25/2018; 17) Noridian Local Coverage Determination L36204- Spinal Cord Stimulators for Chronic Pain; Effective 06/01/2016; Revised 12/01/2019; 18) Noridian Local Coverage Determination L35136 – Spinal Cord Stimulators for Chronic Pain; Effective 10/01/2015; Revised 12/01/2019; 19) Noridian Local Coverage Article A57791 – Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 12/01/2019; 20) American Hospital Association (AHA) Coding Clinic for HCPCS; 21) American Medical Association (AMA) Current Procedure Terminology Assistant; 22) National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VIII – Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory	Complex	5/29/2021	Approved