Cotiviti Approved Issues List as of June 14, 2019

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 - Complex Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	1) CMS Program Integrity Manual Ch. 6.5.3 A-C DRG Validation Review; 2) CMS QIO Manual Section 4130; 3) ICD-9 & 10 CM Coding Manual; 4) ICD-9 & 10 CM Addendums; 5) ICD-9 & 10 CM Official Guidelines for Coding and Reporting, and Addendums; 6) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 7) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017 0:00	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 - Complex Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) CMS Program Integrity Manual Ch. 6.5.3 A-C DRG Validation Review; 2) CMS QIO Manual Section 4130; 3) ICD-9 & 10 CM Coding Manual; 4) ICD-9 & 10 CM Addendums; 5) ICD-9 & 10 CM Official Guidelines for Coding and Reporting, and Addendums; 6) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 7) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017 0:00	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 - Complex Cataract Removal	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states; excluding WPS	1) CMS NCD Chapter 1 part 1 Coverage Determinations section 10 Anesthesia and Pain Management 10.1- Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery, Effective 8/31/1992; 2) CMS NCD Chapter 1 part 1 Coverage Determinations section 80 Eye, 80.10 Phaco-Emulsification Procedure - Cataract Extraction; 3) CMS NCD Chapter 1 part 1 Coverage Determinations, section 80 Eye, 80.12 Intraocular Lenses (IOLs), Effective 5/19/1997; 4) CGS LCD L33954 Cataract Extraction, Effective Date 10/01/2015, Revision 10/01/2016; 5) NGS LCD L33558 Cataract Extraction, effective date 10/1/2015, Revision 11/1/2016; 6) Noridian LCD L34203 Cataract Surgery in Adults, Effective Date 10/01/2015, Revision Effective 10/10/2017; 7) Noridian LCD L37027 Cataract Surgery in Adults, Effective Date 10/10/2017; 8) Palmetto LCD L34413 Cataract Surgery, Effective Date 10/01/2015; Revision 03/14/2016, Revision 05/19/2016, Revision 10/01/2016, Revision 05/11/2017, Revision 06/11/2017, Revision 07/10/2017, Revision 01/29/2018, Revision 02/26/2018; 9) Palmetto Article A53047 Complex Cataract Surgery: Appropriate Use and Documentation, Effective Date 10/01/2015, Revision 05/11/2017, Revision 01/29/2018, Revision 02/26/2018; 10) Novitas LCD L35091 Cataract Extraction (including Complex Cataract Surgery), Effective Date 10/01/2015, Revision Effective 08/10/2017; 11) First Coast LCD L33808 Cataract Extraction, Effective Date 10/01/2015; 12) Cahaba LCD L34287 Cataract Extraction, Effective Date 10/01/2015 PART B ONLY, ending 02/26/2018	Complex	2/12/2017 0:00	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 - Complex Cataract Removal	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) CMS NCD Chapter 1 part 1 Coverage Determinations section 10 Anesthesia and Pain Management 10.1- Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery, Effective 8/31/1992; 2) CMS NCD Chapter 1 part 1 Coverage Determinations section 80 Eye, 80.10 Phaco-Emulsification Procedure - Cataract Extraction; 3) CMS NCD Chapter 1 part 1 Coverage Determinations, section 80 Eye, 80.12 Intraocular Lenses (IOLs), Effective 5/19/1997; 4) CGS LCD L33954 Cataract Extraction, Effective Date 10/01/2015, Revision 10/01/2016; 5) NGS LCD L33558 Cataract Extraction, effective date 10/1/2015, Revision 11/1/2016; 6) Noridian LCD L34203 Cataract Surgery in Adults, Effective Date 10/01/2015, Revision Effective 10/10/2017; 7) Noridian LCD L37027 Cataract Surgery in Adults, Effective Date 10/10/2017; 8) Palmetto LCD L34413 Cataract Surgery, Effective Date 10/01/2015; Revision 03/14/2016, Revision 05/19/2016, Revision 10/01/2016, Revision 05/11/2017, Revision 06/11/2017, Revision 07/10/2017, Revision 01/29/2018, Revision 02/26/2018; 9) Palmetto Article A53047 Complex Cataract Surgery: Appropriate Use and Documentation, Effective Date 10/01/2015, Revision 05/11/2017, Revision 01/29/2018, Revision 02/26/2018; 10) Novitas LCD L35091 Cataract Extraction (including Complex Cataract Surgery), Effective Date 10/01/2015, Revision Effective 08/10/2017; 11) First Coast LCD L33808 Cataract Extraction, Effective Date 10/01/2015; 12) Cahaba LCD L34287 Cataract Extraction, Effective Date 10/01/2015 PART B ONLY, ending 02/26/2018	Complex	2/12/2017 0:00	Approved
Documentation will be reviewed to determine if Sacral Neurostimulation meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient, Outpatient, ASC, Physician	3 years prior to the ADR Letter date	2 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 9/14/2017; Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 9/30/2016; CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; 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 0:00	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 Sacral Neurostimulation meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient, Outpatient, ASC, Physician	3 years prior to the ADR Letter date	3 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 9/14/2017; Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 9/30/2016; CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; 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 0:00	Approved
Medical Necessity and Documentation Review	0004 - SNF Review: Documentation and Medical Necessity	SNF	3 years prior to the ADR Letter date	2 - all applicable states	42 Code of Federal Regulations § 409.30-409.36 Basic Requirements; 42 Code of Federal Regulations § 424.20 Requirements for posthospital SNF care; 42 Code of Federal Regulations § 483.20 Resident assessment; 42 Code of Federal Regulations §§411.15(k)(1); Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; IOM 100-01 Medicare General Information, Eligibility and Entitlement Manual, Chapter 4, § 40.4-40.5 Timing of Recertifications for Extended Care Services; IOM 100-08 Medicare Program Integrity Manual, Chapter 6 Medicare Contractor Medical Review, § 6.1 Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills, and 6.3 Medical Review of Certification and Recertification of Residents in SNFs, and Chapter 6, §6.1.4 Bill Review Process; IOM 100-02 Medicare Benefit Policy Manual , Chapter 8 Coverage of Extended Care (SNF) Services Under Hospital Insurance § 20-40; IOM 100-02 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 0:00	Approved
Medical Necessity and Documentation Review	0004 - SNF Review: Documentation and Medical Necessity	SNF	3 years prior to the ADR Letter date	3 - all applicable states	42 Code of Federal Regulations § 409.30-409.36 Basic Requirements; 42 Code of Federal Regulations § 424.20 Requirements for posthospital SNF care; 42 Code of Federal Regulations § 483.20 Resident assessment; 42 Code of Federal Regulations §§411.15(k)(1); Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; IOM 100-01 Medicare General Information, Eligibility and Entitlement Manual, Chapter 4, § 40.4-40.5 Timing of Recertifications for Extended Care Services; IOM 100-08 Medicare Program Integrity Manual, Chapter 6 Medicare Contractor Medical Review, § 6.1 Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills, and 6.3 Medical Review of Certification and Recertification of Residents in SNFs, and Chapter 6, §6.1.4 Bill Review Process; IOM 100-02 Medicare Benefit Policy Manual , Chapter 8 Coverage of Extended Care (SNF) Services Under Hospital Insurance § 20-40; IOM 100-02 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 0:00	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	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA): Section 1862(a)(1)(A); CMS Publication 100-03.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; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; First Coast LCD L33411: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; First Coast LCD L29317: Effective 2/2/2009; Revised 2/19/2015; Retired 9/30/2015; First Coast LCD L33019: Effective 1/29/2013; Revised 2/19/2015; Retired 9/30/2015; NGS LCA A52447: Effective 10/1/2015; Revision 10/1/2018; NGS LCA A51967: Effective 10/1/2012; Revised 9/1/2014; Retired 9/30/2015; Novitas LCD L35022: Effective 10/1/2015; Revised 1/1/2017; Novitas LCD L32619: Effective 8/13/2012; Revised 10/2/2014; Retired 9/30/2015; Novitas LCD L34495: Effective 12/5/2013; Revised 10/3/2014; Retired 9/30/2015; Noridian LCD L32866: Effective 3/5/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCD L33362: Effective 8/26/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCD L33533: Effective 9/16/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCA A53026: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; Noridian LCA A53028: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; Noridian LCA A50227: Effective 10/20/2008; Revised 1/1/2015; Retired 9/30/2015; Noridian LCA A52803: Effective 3/24/2014; Revised 1/1/2015; Retired 9/30/2015; Palmetto GBA LCD L34576: Effective 10/1/2015; Revised 7/1/2017; Revised 02/26/2018; Palmetto GBA LCD L32975: Effective 3/11/2013; Revised 8/27/2015; Retired 9/30/2015; WPS LCA A54923: Effective 3/1/2016; Revised 3/1/2017; Revised 10/01/2017 and 03/01/2018 and 10/1/18	Complex	1/23/2017 0:00	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	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA): Section 1862(a)(1)(A); CMS Publication 100-03.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; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; First Coast LCD L33411: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; First Coast LCD L29317: Effective 2/2/2009; Revised 2/19/2015; Retired 9/30/2015; First Coast LCD L33019: Effective 1/29/2013; Revised 2/19/2015; Retired 9/30/2015; NGS LCA A52447: Effective 10/1/2015; Revision 10/1/2018; NGS LCA A51967: Effective 10/1/2012; Revised 9/1/2014; Retired 9/30/2015; Novitas LCD L35022: Effective 10/1/2015; Revised 1/1/2017; Novitas LCD L32619: Effective 8/13/2012; Revised 10/2/2014; Retired 9/30/2015; Novitas LCD L34495: Effective 12/5/2013; Revised 10/3/2014; Retired 9/30/2015; Noridian LCD L32866: Effective 3/5/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCD L33362: Effective 8/26/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCD L33533: Effective 9/16/2013; Revised 1/1/2015; Retired 9/30/2015; Noridian LCA A53026: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; Noridian LCA A53028: Effective 10/1/2015; Revised 10/1/2016; Revised 10/01/2017; Noridian LCA A50227: Effective 10/20/2008; Revised 1/1/2015; Retired 9/30/2015; Noridian LCA A52803: Effective 3/24/2014; Revised 1/1/2015; Retired 9/30/2015; Palmetto GBA LCD L34576: Effective 10/1/2015; Revised 7/1/2017; Revised 02/26/2018; Palmetto GBA LCD L32975: Effective 3/11/2013; Revised 8/27/2015; Retired 9/30/2015; WPS LCA A54923: Effective 3/1/2016; Revised 3/1/2017; Revised 10/01/2017 and 03/01/2018 and 10/1/18	Complex	1/23/2017 0:00	Approved
Cataract removal can only occur once per eye during a lifetime. This issue identifies overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye in the look back period.	0009 - Automated Cataract Surgery Once in a Lifetime	Outpatient Hospital, ASC	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); CMS Pub 100-08, Ch. 3, §3.6; National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	1/23/2017 0:00	Approved
Cataract removal can only occur once per eye during a lifetime. This issue identifies overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye in the look back period.	0009 - Automated Cataract Surgery Once in a Lifetime	Outpatient Hospital, ASC	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); CMS Pub 100-08, Ch. 3, §3.6; National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	1/23/2017 0:00	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, Physician	3 years prior to the ADR Letter date	3 - Florida, PR and VI ONLY	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4, Section 220.6.1- PET for Perfusion of the Heart, Effective 4/03/2009; Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4, Section 220.6.8- FDG PET for Myocardial Viability, Effective 1/28/2005; Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 50-Nuclear Medicine; Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 60- Positron Emission Tomography (PET) Scans- General Information; Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, Section 60.9- Coverage of PET Scans for Myocardial Viability; 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; Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, Section 13.5.1- Reasonable and Necessary Provisions in LCDs; First Coast Service Options, Inc. 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; First Coast Service Options, Inc. 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; First Coast Service Options, Inc. LCD L29455- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 3/02/2009; Retired 6/29/2015; First Coast Service Options, Inc. LCD L28954- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 3/02/2009; Retired 6/29/2015; First Coast Service Options, Inc. LCD L28933- Myocardial Imaging, Positron Emission Tomography (PET) Scan, Effective 2/16/2009; Retired 6/29/2015; First Coast Service Options, Inc. LCD L29231- Myocardial Imaging,	Complex	1/24/2017 0:00	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 E&M Codes During Inpatient	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; CPT Manual 2013-present	Automated	1/29/2017 0:00	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 E&M Codes During Inpatient	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; CPT Manual 2013-present	Automated	1/29/2017 0:00	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	Claims Processing Manual (100-04), Chapter 3, Section 190.6.4; Claims Processing Manual (100-04), Chapter 3, Section 190.6.4.1; Claims Processing Manual (100-04), Chapter 3, Section 190.10.1	Automated	2/27/2017 0:00	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	Claims Processing Manual (100-04), Chapter 3, Section 190.6.4; Claims Processing Manual (100-04), Chapter 3, Section 190.6.4.1; Claims Processing Manual (100-04), Chapter 3, Section 190.10.1	Automated	2/27/2017 0:00	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, Physician	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; NCCI Manuals, 2015, 2016, 2017, and 2018 Chapter 1 – General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; NCCI Manuals, 2015, 2016, 2017, and 2018 Chapter 11 – Medicine & E/M CPT Codes 9000-9999 for National Correct Coding Initiative Policy Manual for Medicare; CPT Manual	Complex	4/3/2017 0:00	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, Physician	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A) Exclusions from Coverage and Medicare as a Secondary Payer; NCCI Manuals, 2015, 2016, 2017, and 2018 Chapter 1 – General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; NCCI Manuals, 2015, 2016, 2017, and 2018 Chapter 11 – Medicine & E/M CPT Codes 9000-9999 for National Correct Coding Initiative Policy Manual for Medicare; CPT Manual	Complex	4/3/2017 0:00	Approved
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 (AWV)	Physician/Non-physician Practitioner	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, §§1861(s)(2)(FF) and 1861(hhh); 42 CFR §410.15, §411.15(a)(1), §411.15(k)(15); Internet Only Manual, CMS Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5 (Annual Wellness Visit [AWV] Providing Personalized Prevention Plan Services [PPPS]) (Effective 5/10/2013); Internet Only Manual, CMS Pub. 100-04, 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); Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Sections 140 – 140.8 (Effective 1/1/2011)	Automated	4/26/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 (AWV)	Physician/Non-physician Practitioner	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, §§1861(s)(2)(FF) and 1861(hhh); 42 CFR §410.15, §411.15(a)(1), §411.15(k)(15); Internet Only Manual, CMS Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5 (Annual Wellness Visit [AWV] Providing Personalized Prevention Plan Services [PPPS]) (Effective 5/10/2013); Internet Only Manual, CMS Pub. 100-04, 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); Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Sections 140 – 140.8 (Effective 1/1/2011)	Automated	4/26/2017 0:00	Approved
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 0 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-operative and post-operative Evaluation & Management services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 000 include only E&M services rendered on the day of surgery. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0032 - E&M Codes billed within a Procedure Code with a 0 Day Global Period (Endoscopies or minor surgical procedures)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.3 Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum – MPFSDB Record Layouts (Rev. 3876, Issued:10-06-17, -Implementation: 04-02-18)	Automated	12/12/2017	Closed
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 0 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-operative and post-operative Evaluation & Management services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 000 include only E&M services rendered on the day of surgery. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0032 - E&M Codes billed within a Procedure Code with a 0 Day Global Period (Endoscopies or minor surgical procedures)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.3 Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum – MPFSDB Record Layouts (Rev. 3876, Issued:10-06-17, -Implementation: 04-02-18)	Automated	12/12/2017	Closed
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 10 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 010 include only E&M services on the day of the procedure and up to 10 post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0033 - E&M Codes billed within a Procedure Code with a 10 Day Global Period (other minor procedures)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act, Section 1833[42 U.S.C. 1395l](e); Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §40.3, Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10, 01-01-2012-ASC X12; Implementation: 08-25-2014-ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum–MPFSDB Record Layouts (Rev. 3693, Issued: 01-13-17, Effective: 01-01-17-Implementation: 01-03-17)	Automated	12/12/2017	Closed

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 10 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 010 include only E&M services on the day of the procedure and up to 10 post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0033 - E&M Codes billed within a Procedure Code with a 10 Day Global Period (other minor procedures)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833[42 U.S.C. 1395l](e); Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §40.3, Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10, 01-01-2012-ASC X12; Implementation: 08-25-2014-ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum–MPFSDB Record Layouts (Rev. 3693, Issued: 01-13-17, Effective: 01-01-17-Implementation: 01-03-17)	Automated	12/12/2017	Closed
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 90 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 090 include only E&M services on the day before the procedure, the day of the procedure and up to 90 days post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0034 - E&M Codes billed within a Procedure Code with a 90 Day Global Period (major surgeries)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.3 Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum – MPFSDB Record Layouts (Rev. 3876, Issued:10-06-17, -Implementation: 04-02-18)	Automated	12/12/2017	Closed
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 90 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 090 include only E&M services on the day before the procedure, the day of the procedure and up to 90 days post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0034 - E&M Codes billed within a Procedure Code with a 90 Day Global Period (major surgeries)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.3 Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum – MPFSDB Record Layouts (Rev. 3876, Issued:10-06-17, -Implementation: 04-02-18)	Automated	12/12/2017	Closed
Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines.	0036 - Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed	Physician, Outpatient Hospital, Professional Services	3 years prior to the ADR Letter date	2 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] €; Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40	Complex	2/27/2017 0:00	Approved
Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines.	0036 - Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed	Physician, Outpatient Hospital, Professional Services	3 years prior to the ADR Letter date	3 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] €; Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40	Complex	2/27/2017 0:00	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 - Excessive Units of Hospital Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §§30.6.9-30.6.9.1 and Chapter 12, §30.6.9.2; American Medical Association (AMA), Current Procedure Terminology 2007 to 2017	Automated	3/23/2017 0:00	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 - Excessive Units of Hospital Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §§30.6.9-30.6.9.1 and Chapter 12, §30.6.9.2; American Medical Association (AMA), Current Procedure Terminology 2007 to 2017	Automated	3/23/2017 0:00	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	Physician, Professional Services	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, § 30.6.9. (D). D. Visits to Patients in Swing Beds	Automated	3/23/2017 0:00	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	Physician, Professional Services	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, § 30.6.9. (D). D. Visits to Patients in Swing Beds	Automated	3/23/2017 0:00	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 - CPT 92002 and 92004: Incorrect Coding	Physician, Professional Services	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, (Physicians/Non-physician Practitioner's), § 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016)	Automated	3/23/2017 0:00	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 - CPT 92002 and 92004: Incorrect Coding	Physician, Professional Services	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, (Physicians/Non-physician Practitioner's), § 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016)	Automated	3/23/2017 0:00	Approved
Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.	0040 - Hospital Discharge Day Management Service	Physician, Professional Services	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.9.2	Automated	3/23/2017 0:00	Closed
Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.	0040 - Hospital Discharge Day Management Service	Physician, Professional Services	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.9.2	Automated	3/23/2017 0:00	Closed

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
If evaluation and management service are being rendered to patients admitted to an inpatient hospital setting, then CPT Codes 99221-99223, 99231-99233 and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for evaluation and management service provided in the physician's office, in an outpatient or other ambulatory facility	0042 - Office Visits Billed for Hospital Inpatients	Professional Services (Physician/Non-Physician)	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, § 30.6, 30.6.9.1, and 30.6.10.; 7. CPT Coding Manual	Automated	3/23/2017 0:00	Approved
If evaluation and management service are being rendered to patients admitted to an inpatient hospital setting, then CPT Codes 99221-99223, 99231-99233 and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for evaluation and management service provided in the physician's office, in an outpatient or other ambulatory facility	0042 - Office Visits Billed for Hospital Inpatients	Professional Services (Physician/Non-Physician)	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, § 30.6, 30.6.9.1, and 30.6.10.; 7. CPT Coding Manual	Automated	3/23/2017 0:00	Approved
Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Internet Only Manual, CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016), 30.6.1.1 (Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]) (Effective 1/27/2014), and 30.6.9 (Payment for Inpatient Hospital Visits – General) (Effective 1/1/2011); AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017 0:00	Approved
Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Internet Only Manual, CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016), 30.6.1.1 (Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]) (Effective 1/27/2014), and 30.6.9 (Payment for Inpatient Hospital Visits – General) (Effective 1/1/2011); AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017 0:00	Approved
Potential incorrect billing occurred when Panretinal (Scatter) Laser Photocoagulation (CPT code 67228) is paid more than once, per eye, within the global surgery period	0047 - Panretinal (Scatter) Laser Photocoagulation - Excess Frequency	Outpatient Hospital (OPH), Physician/Non-physician	3 years prior to the Informational Letter date	2 - NGS states only: IL, MN, WI	Title XVIII of the Social Security Act (SSA): §1833(e); Title XVIII of the Social Security Act (SSA): §1862(a)(1)(A); CMS Publication 100-08, Program Integrity Manual, Chapter 3, §3.5.1 (Re-opening Claims) and §3.6 (Determinations Made During Review); CGS Administrators, LLC (CGS) Local Coverage Determination (LCD) L31888 (Retired 9/30/2015); CGS LCD L34064 - Effective – 10/01/2015 (Revised 10/1/2016); National Government Services (NGS) LCD L28497 (Retired 9/30/2015); NGS LCD L33628- Effective -- 10/01/2015 (Revised 10/1/2016)	Automated	4/26/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Ambulance claims for SNF to SNF transfers (modifier NN) are not separately payable under Part B. The SNF discharging the Beneficiary to another SNF is financially responsible for the transportation fees. Ambulance providers should seek payment from the transferring SNF.	0049 - Ambulance SNF to SNF Transfer	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: Publication 100-04; Chapter 6, §20.3.1, and Chapter 15, § 30.2.2; 7. American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; 8. Medicare Benefit Policy Manual: Publication 100-02; Chapter 10, §10.3.3	Automated	8/8/2017 0:00	Approved
Ambulance claims for SNF to SNF transfers (modifier NN) are not separately payable under Part B. The SNF discharging the Beneficiary to another SNF is financially responsible for the transportation fees. Ambulance providers should seek payment from the transferring SNF.	0049 - Ambulance SNF to SNF Transfer	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: Publication 100-04; Chapter 6, §20.3.1, and Chapter 15, § 30.2.2; 7. American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; 8. Medicare Benefit Policy Manual: Publication 100-02; Chapter 10, §10.3.3	Automated	8/8/2017 0:00	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	Physician, Professional Services/Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	1) Social Security Act, Section 1833. [42 U.S.C. 1395l] (e) - Payment of Benefits; 2) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 3) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; 4) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.8. Claims for Co-Surgeons and Team Surgeons, § 40.9 - Procedures Billed With Two or More Surgical Modifiers; 5) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens	Automated	4/26/2017 0:00	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	Physician, Professional Services/Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	1) Social Security Act, Section 1833. [42 U.S.C. 1395l] (e) - Payment of Benefits; 2) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 3) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; 4) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.8. Claims for Co-Surgeons and Team Surgeons, § 40.9 - Procedures Billed With Two or More Surgical Modifiers; 5) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens	Automated	4/26/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or profession (modifier 26) components for the same service.	0051 - Automated Global vs. TC/PC Split Reimbursements	Outpatient Hospital, Physician/NPP, Lab/Ambulance	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1(General Billing Requirements), §120 (Detection of Duplicate Claims); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); CMS Publication 100-04, 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); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients)	Automated	4/26/2017 0:00	Approved
When providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or profession (modifier 26) components for the same service.	0051 - Automated Global vs. TC/PC Split Reimbursements	Outpatient Hospital, Physician/NPP, Lab/Ambulance	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1(General Billing Requirements), §120 (Detection of Duplicate Claims); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); CMS Publication 100-04, 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); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients)	Automated	4/26/2017 0:00	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.	0054 - Ambulance during Inpatient Hospital Stay	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 3, § 10.5; Medicare Claims Processing Manual: Publication 100-04; Chapter 15, § 30.1.4	Automated	6/20/2017 0:00	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.	0054 - Ambulance during Inpatient Hospital Stay	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 3, § 10.5; Medicare Claims Processing Manual: Publication 100-04; Chapter 15, § 30.1.4	Automated	6/20/2017 0:00	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 (E/M) Coding in Skilled Nursing Facilities	Physician/Non-physician Practitioner (NPP)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), §1833(e); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §30.6.13; AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017 0:00	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 (E/M) Coding in Skilled Nursing Facilities	Physician/Non-physician Practitioner (NPP)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), §1833(e); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §30.6.13; AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017 0:00	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	Outpatient Hospital, ASC, Physician/Non-Physician	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, The Medicare Benefit Policy Manual, Chapter 16 §20; National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy - Effective January 1, 2014- January 1, 2017; Revised	Complex	9/8/2017 0:00	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	Outpatient Hospital, ASC, Physician/Non-Physician	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, The Medicare Benefit Policy Manual, Chapter 16 §20; National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy Effective January 1, 2014- January 1, 2017; Revised	Complex	9/8/2017 0:00	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 bill column per date of service.	0060 - Excessive Units - Untimed Therapy	OPH, OP Non-Hospital, SNF, ORF, CORF, Physician	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); CMS Pub 100-04, Ch. 5, § 20.2; American Medical Association (AMA), Current Procedure Terminology 2014 to current; Medicare Benefit Policy Manual: Chapter 15, Sections 220 and 230; CMS Pub 100-04 CR 9698 December 1, 2016 (Transmittal 3670)	Automated	9/8/2017 0:00	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 bill column per date of service.	0060 - Excessive Units - Untimed Therapy	OPH, OP Non-Hospital, SNF, ORF, CORF, Physician	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); CMS Pub 100-04, Ch. 5, § 20.2; American Medical Association (AMA), Current Procedure Terminology 2014 to current; Medicare Benefit Policy Manual: Chapter 15, Sections 220 and 230; CMS Pub 100-04 CR 9698 December 1, 2016 (Transmittal 3670)	Automated	9/8/2017 0:00	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 - Excessive Units of Nursing Facility Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.13 (B); American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017 0:00	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 - Excessive Units of Nursing Facility Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.13 (B); American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017 0:00	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 - TC of Radiology Inpatient - FULL	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	2 - all applicable states	Medicare Claims Processing Manual 100-04; Chapter 13, § 20.2.1; Change Request 5675; Medicare Claims Processing Manual 100-04; Chapter 26, § 10.7 - Type of Service	Automated	9/8/2017 0:00	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 - TC of Radiology Inpatient - FULL	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	3 - all applicable states	Medicare Claims Processing Manual 100-04; Chapter 13, § 20.2.1; Change Request 5675; Medicare Claims Processing Manual 100-04; Chapter 26, § 10.7 - Type of Service	Automated	9/8/2017 0:00	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 - Initial Critical Care- CPT 99291: Excessive Units	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.12 Sections (F), (G) and (I)	Automated	9/8/2017 0:00	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 - Initial Critical Care- CPT 99291: Excessive Units	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.12 Sections (F), (G) and (I)	Automated	9/8/2017 0:00	Approved
Duplicate claim or line date of service items are those where the same service is rendered and paid multiple times on the same date of service for the same beneficiary	0064 - Facility Duplicate Claims	IP, OP, SNF, OP Clinics, ORF, CORF	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04, Chapter 1, §120.2 (A); Medicare Financial Management Manual: Publication 100-06, Chapter 3, §10.2	Automated	9/8/2017 0:00	Approved
Duplicate claim or line date of service items are those where the same service is rendered and paid multiple times on the same date of service for the same beneficiary.	0064 - Facility Duplicate Claims	IP, OP, SNF, OP Clinics, ORF, CORF	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04, Chapter 1, §120.2 (A); Medicare Financial Management Manual: Publication 100-06, Chapter 3, §10.2	Automated	9/8/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Hospital emergency department services are not payable for the same calendar date as critical care services when 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	Physician/NPP	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.12 (H) & (I)	Automated	10/5/2017 0:00	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	Physician/NPP	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.12 (H) & (I)	Automated	10/5/2017 0:00	Approved
When administering multiple infusions, injections or combinations, the physician should only report one initial" service code unless protocol requires that two separate IV sites must be used. For these separate identifiable services, physicians need to report with using modifier 59, XE, XS, XP, or XU.	0071 - Initial Hydration, Infusion and Chemotherapy Administration	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.5(e), effective 6/26/2006	Automated	10/10/2017 0:00	Approved
When administering multiple infusions, injections or combinations, the physician should only report one initial" service code unless protocol requires that two separate IV sites must be used. For these separate identifiable services, physicians need to report with using modifier 59, XE, XS, XP, or XU.	0071 - Initial Hydration, Infusion and Chemotherapy Administration	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.5(e), effective 6/26/2006	Automated	10/10/2017 0:00	Approved
Payment may not be made for outpatient services overlapping or during an inpatient stay.	0072 - Outpatient Service Overlapping or During an Inpatient Stay	Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Claims Processing Manual: Publication 100-04; Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicate Claims- Submission of Institutional Claims; Medicare Claims Processing Manual: Publication 100-04; Chapter 3- Inpatient Hospital Billing, §40.3.B- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Testing; Medicare Claims Processing Manual: Publication 100-04; Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; Medicare Claims Processing Manual: Publication 100-04; 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); Medicare Claims Processing Manual: Publication 100-04; Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; Medicare Claims Processing Manual: Publication 100-04; Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; Medicare Financial Management Manual: Publication 100-06; Chapter 3- Overpayments, §10.2- Individual Overpayments; Medical Benefit Policy Manual: Publication 100-2; Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; Medical Benefit Policy Manual: Publication 100-2; Chapter 10- Ambulance Services, §10- Ambulance Services & §20- Coverage Guidelines for Ambulance Service Claims; Medical Benefit Policy Manual: Publication 100-2; Chapter 10- Ambulance Services, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Payment may not be made for outpatient services overlapping or during an inpatient stay.	0072 - Outpatient Service Overlapping or During an Inpatient Stay	Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Claims Processing Manual: Publication 100-04; Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicate Claims- Submission of Institutional Claims; Medicare Claims Processing Manual: Publication 100-04; Chapter 3- Inpatient Hospital Billing, §40.3.B- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Testing; Medicare Claims Processing Manual: Publication 100-04; Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; Medicare Claims Processing Manual: Publication 100-04; 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); Medicare Claims Processing Manual: Publication 100-04; Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; Medicare Claims Processing Manual: Publication 100-04; Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; Medicare Financial Management Manual: Publication 100-06; Chapter 3- Overpayments, §10.2- Individual Overpayments; Medical Benefit Policy Manual: Publication 100-2; Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; Medical Benefit Policy Manual: Publication 100-2; Chapter 10- Ambulance Services, §10- Ambulance Services & §20- Coverage Guidelines for Ambulance Service Claims; Medical Benefit Policy Manual: Publication 100-2; Chapter 10- Ambulance Services, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017 0:00	Approved
Inpatient hospital services furnished to a patient in an inpatient rehabilitation facility will be reviewed to determine that services were medically reasonable and necessary	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 0:00	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 in an inpatient rehabilitation facility will be reviewed to determine that services were medically reasonable and necessary	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 0:00	Approved
Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that 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 not a multiple of the 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, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units.	0074 - Excessive or Insufficient Drugs and Biologicals Units Billed	Outpatient Hospital; Physician	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. CMS IOM 100-04, 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; and §90.2 Drugs, Biologicals, and Radiopharmaceuticals; 7. Medicare Alpha-Numeric HCPCS File; 8. Annual American Medical Association: CPT Manual; 9. Annual HCPCS Level II Manual; 10. Medicare Part B Drug Average Sales Price; ASP Pricing File; 11. U.S. National Library of Medicine DailyMed; 12. Attached list of HCPCS Codes for Drugs and Biologicals	Complex	12/21/2017 0:00	Approved
Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that 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 not a multiple of the 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, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units.	0074 - Excessive or Insufficient Drugs and Biologicals Units Billed	Outpatient Hospital; Physician	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. CMS IOM 100-04, 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; and §90.2 Drugs, Biologicals, and Radiopharmaceuticals; 7. Medicare Alpha-Numeric HCPCS File; 8. Annual American Medical Association: CPT Manual; 9. Annual HCPCS Level II Manual; 10. Medicare Part B Drug Average Sales Price; ASP Pricing File; 11. U.S. National Library of Medicine DailyMed; 12. Attached list of HCPCS Codes for Drugs and Biologicals	Complex	12/21/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Except when reported with modifier 25, payment for certain evaluation and management services is bundled into the payment for dialysis services 90935, 90937, 90945, and 90947.	0076 - Evaluation and Management (E/M) Same Day as Dialysis	All physician/NPP specialties	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 8, § 170 (B); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.10	Automated	1/11/2018 0:00	Approved
Except when reported with modifier 25, payment for certain evaluation and management services is bundled into the payment for dialysis services 90935, 90937, 90945, and 90947.	0076 - Evaluation and Management (E/M) Same Day as Dialysis	All physician/NPP specialties	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 8, § 170 (B); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.10	Automated	1/11/2018 0:00	Approved
Annual Wellness Visit (AWV) Billed Sooner Than 11 Whole Months Following the Initial Preventative Physical Examination (IPPE)	0077 - Annual Wellness Visit (AWV) Billed Sooner Than 11 Whole Months Following the Initial Preventative Physical Examination (IPPE)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 42 CFR §411.15-Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services that are not Reasonable and Necessary, (15); Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV); CMS Change Request (CR) 7079 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2575CP.pdf; CMS Change Request (CR) 8107 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2575CP.pdf	Automated	1/9/2018 0:00	Approved
Annual Wellness Visit (AWV) Billed Sooner Than 11 Whole Months Following the Initial Preventative Physical Examination (IPPE)	0077 - Annual Wellness Visit (AWV) Billed Sooner Than 11 Whole Months Following the Initial Preventative Physical Examination (IPPE)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 42 CFR §411.15-Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services that are not Reasonable and Necessary, (15); Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV); CMS Change Request (CR) 7079 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2575CP.pdf; CMS Change Request (CR) 8107 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2575CP.pdf	Automated	1/9/2018 0:00	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 - Complex Cardiac Pacemaker Review	OP, ASC	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (Section 1862(a)(1)(A); 42 CFR §§405.980(b) and (c); 42 CFR §§ 405.986; CMS Pub. 100-03, Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3, Effective Date of this Version 8/13/2013; Social Security Act (SSA), 1833(e); 42 Code of Federal Regulations §424.5(a)(6); 42 Code of Federal Regulations §411.15(k)(1); Cahaba Local Coverage Article A54949, Effective Date 4/15/2016; First Coast Local Coverage Article A54926, Effective date 5/1/2016; NGS Local Coverage Article A54909, Effective Date 4/15/2016; Novitas Local Coverage Article A54982, Effective Date 5/1/2016; Palmetto Local Coverage Article A54831, Effective Date 01/13/2016; WPS Local Coverage Article A54958, Effective Date 5/15/2016; CGS Local Coverage Article A54961, Effective 05/01/2016 ; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018 0:00	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 - Complex Cardiac Pacemaker Review	OP, ASC	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (Section 1862(a)(1)(A); 42 CFR §§405.980(b) and (c); 42 CFR §§ 405.986; CMS Pub. 100-03, Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3, Effective Date of this Version 8/13/2013; Social Security Act (SSA), 1833(e); 42 Code of Federal Regulations §424.5(a)(6); 42 Code of Federal Regulations §411.15(k)(1); Cahaba Local Coverage Article A54949, Effective Date 4/15/2016; First Coast Local Coverage Article A54926, Effective date 5/1/2016; NGS Local Coverage Article A54909, Effective Date 4/15/2016; Novitas Local Coverage Article A54982, Effective Date 5/1/2016; Palmetto Local Coverage Article A54831, Effective Date 01/13/2016; WPS Local Coverage Article A54958, Effective Date 5/15/2016; CGS Local Coverage Article A54961, Effective 05/01/2016 ; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018 0:00	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. This query identifies overpayments where providers are billing for more than one unit of cataract removal for the same eye, on the same line of the claim.	0083 - Cataract Removal Excessive Units - Partial Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. This query identifies overpayments where providers are billing for more than one unit of cataract removal for the same eye, on the same line of the claim.	0083 - Cataract Removal Excessive Units - Partial Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
CPT Codes describing cataract extraction are mutually exclusive of one another. Only one code from the affected CPT code range may be reported per date of service and for each eye.	0084 - Cataract Removal Excessive Units - Full Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
CPT Codes describing cataract extraction are mutually exclusive of one another. Only one code from the affected CPT code range may be reported per date of service and for each eye.	0084 - Cataract Removal Excessive Units - Full Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	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, according to CMS IOM 100-04 Chapter 3, section 10.4	0085 - Lab Services Rendered During an Inpatient Stay	Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	CMS IOM 100-04 Chapter 3, section 10.4; CPT Coding Book	Automated	3/13/2018 0:00	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, according to CMS IOM 100-04 Chapter 3, section 10.4	0085 - Lab Services Rendered During an Inpatient Stay	Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	CMS IOM 100-04 Chapter 3, section 10.4; CPT Coding Book	Automated	3/13/2018 0:00	Approved
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) codes billed Same Day as Inpatient Admission	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.8 (D)	Automated	3/14/2018 0:00	Approved
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) codes billed Same Day as Inpatient Admission	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.8 (D)	Automated	3/14/2018 0:00	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 - Labs Subject to Part B Consolidated Billing for Clinical Labs - ESRD	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual 100-04; Chapter 8, Section 60.1 (effective 4/01/2015); ESRD PPS Consolidated Billing (files for 2014 – 2017) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 - Labs Subject to Part B Consolidated Billing for Clinical Labs - ESRD	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual 100-04; Chapter 8, Section 60.1 (effective 4/01/2015); ESRD PPS Consolidated Billing (files for 2014 – 2017) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018 0:00	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	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 14, § 40	Automated	3/14/2018 0:00	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	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 14, § 40	Automated	3/14/2018 0:00	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 - CSW (Clinical Social Workers) during Inpatient Hospital	Professional Services	3 years prior to the Informational Letter date	2 – all applicable states	42 CFR 409.10 (a)(4); 42 CFR 410.73; 42 CFR 412.50 (b); Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Title XVIII of the Social Security Act, Section 1861 (hh) and (hh)(2). [42 U.S.C. 13951]; Medicare Benefit Policy Manual 100-02; Chapter 15, Section 170; Medicare Claims Processing Manual 100-04; Chapter 3, Section 10.4; WPS Local Coverage Article A54829; Effective 02/01/2016; Revised 01/01/2017; Revised 03/01/2017; Revised 03/01/2018.	Automated	3/14/2018 0:00	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 - CSW (Clinical Social Workers) during Inpatient Hospital	Professional Services	3 years prior to the Informational Letter date	3 – all applicable states	42 CFR 409.10 (a)(4); 42 CFR 410.73; 42 CFR 412.50 (b); Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Title XVIII of the Social Security Act, Section 1861 (hh) and (hh)(2). [42 U.S.C. 13951]; Medicare Benefit Policy Manual 100-02; Chapter 15, Section 170; Medicare Claims Processing Manual 100-04; Chapter 3, Section 10.4; WPS Local Coverage Article A54829; Effective 02/01/2016; Revised 01/01/2017; Revised 03/01/2017; Revised 03/01/2018.	Automated	3/14/2018 0:00	Approved
The technical component (TC) of lab/pathology services furnished to patients in an outpatient hospital setting are not separately payable. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator “3” for TC component only.	0090 - Technical Component of Lab/Pathology for Inpatient and Outpatient Hospitals	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 60 (B); 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 outpatient hospital setting are not separately payable. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator “3” for TC component only.	0090 - Technical Component of Lab/Pathology for Inpatient and Outpatient Hospitals	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 60 (B); 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 Payment - Exact	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Financial Management Manual: Publication 100-06; Chapter 3, Section 10.2; Medicare Claims Processing Manual: Publication 100-04; Chapter 1, § 120.2 (B); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2; Medicare Claims Processing Manual: Publication 100-04; Chapter 26, § 10.5	Automated	5/8/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider.	0091- Duplicate Payment - Exact	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Financial Management Manual: Publication 100-06; Chapter 3, Section 10.2; Medicare Claims Processing Manual: Publication 100-04; Chapter 1, § 120.2 (B); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2; Medicare Claims Processing Manual: Publication 100-04; Chapter 26, § 10.5	Automated	5/8/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Providers that submit and were paid for code, 64553 and/ or code 64555 must support in the documentation that the code billed was actually the service rendered and that all coverage criteria were met.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Documentation Requirements	Outpatient Hospital, (OPH); Ambulatory Surgery Center (ASC); Physician/Non-physician Practitioner (NPP)	3 years prior to ADR Letter date	2 – all applicable states	1. Title XVIII of the Social Security Act (SSA): §§1833(e); 1862(a)(1)(A); 1862(a)(10). Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules; 4. 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; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements 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; 6. 42 CFR §405.986- Good Cause for reopening; 7. Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §160.7.1 (Updated through Rev. 149, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13); 8. Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §30.3 (Rev. 1, 10-03-03); 9. American Medical Association Current Procedural Terminology Manual/ Healthcare Common Procedure Coding System 2014 to current	Complex	5/8/2018	Approved
Providers that submit and were paid for code, 64553 and/ or code 64555 must support in the documentation that the code billed was actually the service rendered and that all coverage criteria were met.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Documentation Requirements	Outpatient Hospital, (OPH); Ambulatory Surgery Center (ASC); Physician/Non-physician Practitioner (NPP)	3 years prior to ADR Letter date	3 – all applicable states	1. Title XVIII of the Social Security Act (SSA): §§1833(e); 1862(a)(1)(A); 1862(a)(10). Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules; 4. 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; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements 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; 6. 42 CFR §405.986- Good Cause for reopening; 7. Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §160.7.1 (Updated through Rev. 149, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13); 8. Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §30.3 (Rev. 1, 10-03-03); 9. American Medical Association Current Procedural Terminology Manual/ Healthcare Common Procedure Coding System 2014 to current	Complex	5/8/2018	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation 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	Outpatient Hospital, ASC, Physician/Non-Physician Practitioner	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4, Section 20.4- Implantable Automatic Defibrillators, Effective 01/27/2005; Revised 2/15/2018; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; Decision Memo for Implantable Cardioverter Defibrillators (CAG-00157R4) available: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=288	Complex	5/14/2018	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	Outpatient Hospital, ASC, Physician/Non-Physician Practitioner	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4, Section 20.4- Implantable Automatic Defibrillators, Effective 01/27/2005; Revised 2/15/2018; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; Medicare Claims Processing Manual, IOM 100-04, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; Decision Memo for Implantable Cardioverter Defibrillators (CAG-00157R4) available: https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=288	Complex	5/14/2018	Approved
Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedure are ranked in descending order by the Medicare Fee Schedule amount. Payment of the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50% of the fee schedule amount. Underpayments occur when claim lines are improperly reduced due to incorrect primary procedure ranking determinations and when modifier 51 is submitted for non- reducible procedures.	0096 - MSU Underpayments	Professional Services (Physician/Non-Physician Practitioner) who perform surgical procedures	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Claims for Multiple Surgeries; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30; Physician Fee Schedule; Addendum - MPFSDB Record Layouts	Automated	6/29/2018	Closed
Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedure are ranked in descending order by the Medicare Fee Schedule amount. Payment of the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50% of the fee schedule amount. Underpayments occur when claim lines are improperly reduced due to incorrect primary procedure ranking determinations and when modifier 51 is submitted for non- reducible procedures.	0096 - MSU Underpayments	Professional Services (Physician/Non-Physician Practitioner) who perform surgical procedures	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Claims for Multiple Surgeries; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30; Physician Fee Schedule; Addendum - MPFSDB Record Layouts	Automated	6/29/2018	Closed

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedure are ranked in descending order by the Medicare Fee Schedule amount. Payment the the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50 of the fee schedule amount. Overpayment occur when secondary/subsequent procedure claim lines are not properly reduced due to incorrect primary procedure ranking determinations.	0097 - MSU Overpayments	Professional Services (Physician/Non-Physician Practitioner) who perform surgical procedures	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Claims for Multiple Surgeries; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30; Physician Fee Schedule; Addendum - MPFSDB Record Layouts	Automated	6/29/2018	Closed
Multiple surgeries are separate procedures performed on the same patient at the same operative session or on the same day for which separate payment may be allowed. When multiple surgical procedures are performed Medicare Physician Fee Schedule (MPFS) rules state that the second and any subsequent procedures are subject to reduced reimbursement. The Medicare Physician Fee Schedule data Base (MPFSDB) Multiple Procedure Indicators reflect the reduction amount, if any, that is applicable for the surgical procedure. Reducible procedure are ranked in descending order by the Medicare Fee Schedule amount. Payment the the procedure with the highest value is based on 100% of the fee schedule amount. Subsequent procedures are paid based on 50 of the fee schedule amount. Overpayment occur when secondary/subsequent procedure claim lines are not properly reduced due to incorrect primary procedure ranking determinations.	0097 - MSU Overpayments	Professional Services (Physician/Non-Physician Practitioner) who perform surgical procedures	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 40.6; Claims for Multiple Surgeries; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, § 30; Physician Fee Schedule; Addendum - MPFSDB Record Layouts	Automated	6/29/2018	Closed
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 - Unbundling of Critical Care	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act – Payment of Benefits, Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; 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- effective 7/25/14	Automated	6/18/2018	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 - Unbundling of Critical Care	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act – Payment of Benefits, Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; 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- effective 7/25/14	Automated	6/18/2018	Approved
Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A SNF stay are included in a bundled prospective payment. Entities that provide these services should look to the SNF for payment. Under the consolidated billing requirement, the SNF must submit all Medicare claims for the entire package of care that residents receive during a covered Part A SNF stay.	0099 - Skilled Nursing Facility (SNF) Consolidated Billing	Outpatient Facility	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6; § 10.1- 20.6	Automated	6/25/2018	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 SNF stay are included in a bundled prospective payment. Entities that provide these services should look to the SNF for payment. Under the consolidated billing requirement, the SNF must submit all Medicare claims for the entire package of care that residents receive during a covered Part A SNF stay.	0099 - Skilled Nursing Facility (SNF) Consolidated Billing	Outpatient Facility	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6; § 10.1- 20.6	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 codes paid without Primary Code and/or denied Primary Code – by Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013); https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html	Automated	6/20/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied.	0100-Add-on codes paid without Primary Code and/or denied Primary Code – by Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70 Time Limitations for Filing Part A and Part B Claims; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8 Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013); 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 procedures affecting or potentially affecting the APC assignment.	0101 - Outpatient Hospital APC Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	42 Code of Federal Regulations §§414, 419; Medicare Claims Processing Manual CMS Publication 100-04 Chapter 4, §§ 10.1- 10.5- 20, 40-61, 100, 120, 150-240, 270, and 300; Medicare Program Integrity Manual CMS Publication 100-08 Chapter 3 §3.6.2.4; 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), Pass-Through Drugs and Biologicals (SI=G), and Nonpass-Through Drugs and Biologicals (SI=K); AMA CPT Assistant; National Correct Coding Initiative Policy Manual; Integrated OCE (IOCE) CMS Specifications Appendix L: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V19.0 Effective 01/01/2018), Appendix D: Computation of Discounting Fraction (OPPS only), and Appendix P: Pass-Through Drugs and Biologicals Processing (OPPS Only, V17.2); 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
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 procedures affecting or potentially affecting the APC assignment.	0101 - Outpatient Hospital APC Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	42 Code of Federal Regulations §§414, 419; Medicare Claims Processing Manual CMS Publication 100-04 Chapter 4, §§ 10.1- 10.5- 20, 40-61, 100, 120, 150-240, 270, and 300; Medicare Program Integrity Manual CMS Publication 100-08 Chapter 3 §3.6.2.4; 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), Pass-Through Drugs and Biologicals (SI=G), and Nonpass-Through Drugs and Biologicals (SI=K); AMA CPT Assistant; National Correct Coding Initiative Policy Manual; Integrated OCE (IOCE) CMS Specifications Appendix L: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V19.0 Effective 01/01/2018), Appendix D: Computation of Discounting Fraction (OPPS only), and Appendix P: Pass-Through Drugs and Biologicals Processing (OPPS Only, V17.2); 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
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. 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 – by ASC	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. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12: Physicians/Nonphysician Practitioners, § 30: Correct Coding Policy; 3. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01: General Billing Requirements § 70 : Time Limitations for Filing Part A and Part B Claims; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16: Laboratory Services § 40.8: Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 5. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29: Appeals of Claims Decisions § 240 (revised 7/23/2013): Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 6. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html; 7. 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 billed. 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 – by ASC	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. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12: Physicians/Nonphysician Practitioners, § 30: Correct Coding Policy; 3. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01: General Billing Requirements § 70 : Time Limitations for Filing Part A and Part B Claims; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16: Laboratory Services § 40.8: Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 5. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29: Appeals of Claims Decisions § 240 (revised 7/23/2013): Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 6. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html; 7. AMA CPT Code book	Automated	7/24/2018	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	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	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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833€; Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2	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	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833€; Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 20.4.2	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	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6, § 20.1.1; 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
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	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6, § 20.1.1; 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.	0110 - Skilled Nursing Facility (SNF) Consolidated Billing Part B - Partial	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6, § 20.1.1; 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
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.	0110 - Skilled Nursing Facility (SNF) Consolidated Billing Part B - Partial	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(d); Medicare Claims Processing Manual: Publication 100-04; Chapter 6, § 20.1.1; 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
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	Inpatient Hospital, Outpatient Hospital, SNF	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (Section 1833(e); Social Security Act (Section 1862(a)(1)(A); Social Security Act (Section 1862(a)(7); 42 CFR §410.32(a) ; 42 CFR §411.15(k)(1); Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §§80.6-80.6.4; Medicare Claims Processing Manual, Pub 100-04, Chapter 9, §100; Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §30.4; CGS LCD L34338; Effective date 10/1/2015; Revised 10/1/2017; First Coast LCD L33768; Effective date 10/1/2015; Revised 10/1/2017; NGS LCD L33577; Effective date 10/1/2015; Revised 11/1/2017; Palmetto LCD L37379; Effective date 9/18/2017; Revised 2/26/2018; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	9/28/2018	Approved
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary	0111 - Transthoracic Echocardiography: Medical Necessity	Inpatient Hospital, Outpatient Hospital, SNF	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (Section 1833(e); Social Security Act (Section 1862(a)(1)(A); Social Security Act (Section 1862(a)(7); 42 CFR §410.32(a) ; 42 CFR §411.15(k)(1); Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, §§80.6-80.6.4; Medicare Claims Processing Manual, Pub 100-04, Chapter 9, §100; Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §30.4; CGS LCD L34338; Effective date 10/1/2015; Revised 10/1/2017; First Coast LCD L33768; Effective date 10/1/2015; Revised 10/1/2017; NGS LCD L33577; Effective date 10/1/2015; Revised 11/1/2017; Palmetto LCD L37379; Effective date 9/18/2017; Revised 2/26/2018; Annual American Medical Association CPT 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	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 8, § 140; §140.1 and §140.4; 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	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 8, § 140; §140.1 and §140.4; American Medical Association (AMA), Current Procedural Terminology 2015 to current	Automated	11/7/2018	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. Providers cannot billed for services that are rendered.	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	Title XVIII of the Social Security Act: Section 1833€; Medicare Claims Processing Manual: Publication 100-04; Chapter 1, § 120.2 (B)	Automated	10/17/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. Providers cannot billed for services that are rendered.	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	Title XVIII of the Social Security Act: Section 1833€; Medicare Claims Processing Manual: Publication 100-04; Chapter 1, § 120.2 (B)	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.	0116 - Improperly Paid Modifiers TC and 26	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; 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.	0116 - Improperly Paid Modifiers TC and 26	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; 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
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.	0117 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Physician/Non- physician Practitioner (NPP); 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	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 §20.; National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014- current	Automated	10/17/2018	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.	0117 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Physician/Non- physician Practitioner (NPP); 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	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 §20.; National Correct Coding Initiative Policy Manual, Chapter 4, 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
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 (NPP)); 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	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 §20.; National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014- current; 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 (NPP)); 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	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 §20.; National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014- current; 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	Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.; Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.; L34980 Lumbar Epidural Injections (Noridian – JF); Effective: 10/01/2015; Revision Effective: DOS on or after 10/01/2017; L34982 Lumbar Epidural injections (Noridian – JE); Effective: 10/01/2015; Revision Effective DOS on or after 10/01/2017; L36920 Epidural Injections for Pain Management (Novitas – JL & JH); Effective: 05/04/2017; Revision Effective DOS on or after 01/01/2018	Complex	10/31/2018	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 or 10-day global surgical period. E&M Codes Included in the Global Package billed with Modifier 57 will be recovered as overpayments as they are not allowed for surgical procedures with a 0 or 10 global surgical period.	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	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12- Physician/ Non Physician Practitioner, § 30.6.6 (Payment for Evaluation and Management Services Provided During Global Period of Surgery) Section C: "CPT modifier '57' – Decision for Surgery Made Within Global Surgical Period, effective 06/01/06	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 or 10-day global surgical period. E&M Codes Included in the Global Package billed with Modifier 57 will be recovered as overpayments as they are not allowed for surgical procedures with a 0 or 10 global surgical period.	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	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12- Physician/ Non Physician Practitioner, § 30.6.6 (Payment for Evaluation and Management Services Provided During Global Period of Surgery) Section C: "CPT modifier '57' – Decision for Surgery Made Within Global Surgical Period, effective 06/01/06	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 - Excessive Units of Destruction of Premalignant Lesions	Professional Services (Physician/non-physician practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions)	Automated	12/4/2018	Automated
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 - Excessive Units of Destruction of Premalignant Lesions	Professional Services (Physician/non-physician practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions)	Automated	12/4/2018	Automated

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 - Unbundling of Outpatient Hospice Related Services	Part A Outpatient	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 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; CMS Benefit Policy Manual 100-02, Chapter 9- Coverage of Hospice Services under Hospital Insurance, §10- Requirements, General	Automated	11/29/2018	Approved
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.	0122 - Unbundling of Outpatient Hospice Related Services	Part A Outpatient	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 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; 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 (TC) of Diagnostic Procedures during an Inpatient Stay	Physician/Non-Physician Practitioner; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)-Payment of Benefits; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum-MPFSDB File Layouts, 2011-2018 File Layout; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23 Fee Schedule Administration and Coding Requirements, § 30 Services Paid Under the Medicare Physician's Fee Schedule; Medicare Benefit Policy Manual: CMS Publication 100-02; 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 (TC) of Diagnostic Procedures during an Inpatient Stay	Physician/Non-Physician Practitioner; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)-Payment of Benefits; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum-MPFSDB File Layouts, 2011-2018 File Layout; Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23 Fee Schedule Administration and Coding Requirements, § 30 Services Paid Under the Medicare Physician's Fee Schedule; Medicare Benefit Policy Manual: CMS Publication 100-02; 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 in a Hospital Setting (Inpatient)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] €; 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 in a Hospital Setting (Inpatient)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] €; 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 residents.	0125 - Excessive Units of Subsequent Hospital and Nursing Facility Care Services (Telehealth)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.3 - List of Medicare Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.2 - Eligibility Criteria (Rev. 2848, Issued 12-30-13; Effective 01-01-14; Implementation 01-06-14)/ (3) Originating site defined; Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.6 - Payment Methodology for Physician/Practitioner at the Distant Site (Rev. 3586, Issued: 08-12-16, Effective: 01-01-17, Implementation: 01-03-17); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18)	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 residents.	0125 - Excessive Units of Subsequent Hospital and Nursing Facility Care Services (Telehealth)	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.3.5 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.3 - List of Medicare Telehealth Services (Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.2 - Eligibility Criteria (Rev. 2848, Issued 12-30-13; Effective 01-01-14; Implementation 01-06-14)/ (3) Originating site defined; Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.6 - Payment Methodology for Physician/Practitioner at the Distant Site (Rev. 3586, Issued: 08-12-16, Effective: 01-01-17, Implementation: 01-03-17); Medicare Claims Processing Manual: Publication 100-04; Chapter 12; Section 190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18)	Automated	2/21/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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 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	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 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; AMA CPT Manual Endoscopy Section; 2015 to current; National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI, §C	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 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	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 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; AMA CPT Manual Endoscopy Section; 2015 to current; National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI, §C	Automated	11/14/2018	Approved
Based on the American Medical Association (AMA), Current Procedural Terminology (CPT), CPT Codes 77001-77003 and 77012 are not to be reported with CPT Codes 64479-64480 and 64483-64484. Codes 64479 – 64484 already include imaging guidance (fluoroscopy or CT) and guidance codes are not be billed in addition to these procedures.	0127 - Transforaminal Epidural Injections Billed with Guidance	Professional Services (Physician/non-physician practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (see description included in CPT manual under Radiologic Guidance/Fluoroscopic Guidance)	Automated	12/21/2018	Approved
Based on the American Medical Association (AMA), Current Procedural Terminology (CPT), CPT Codes 77001-77003 and 77012 are not to be reported with CPT Codes 64479-64480 and 64483-64484. Codes 64479 – 64484 already include imaging guidance (fluoroscopy or CT) and guidance codes are not be billed in addition to these procedures.	0127 - Transforaminal Epidural Injections Billed with Guidance	Professional Services (Physician/non-physician practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (see description included in CPT manual under Radiologic Guidance/Fluoroscopic Guidance)	Automated	12/21/2018	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere pressure. The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 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 (HBOT) For Diabetic Wounds	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 42 Code of Federal Regulations §424.5- Basic Conditions, (a)(6)- Sufficient Information; 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); CMS National Coverage Determination Manual, Ch.1, §20.29 Hyperbaric Oxygen Therapy, Effective date 08/11/1997; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	1/30/2019	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 (HBOT) For Diabetic Wounds	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; 42 Code of Federal Regulations §424.5- Basic Conditions, (a)(6)- Sufficient Information; 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); CMS National Coverage Determination Manual, Ch.1, §20.29 Hyperbaric Oxygen Therapy, Effective date 08/11/1997; 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; 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; 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 a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.	0132 - Evaluation and Management (E/M) Same Day as Admission to a Nursing Facility	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 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; 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; 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 a physician for an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.	0132 - Evaluation and Management (E/M) Same Day as Admission to a Nursing Facility	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 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; 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; 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 - PET Scans Paid without Tracer Codes for IDTF (Independent Diagnostic Testing Facility) Providers	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); 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; CMS Publication 100-04; Chapter 13, § 60.3.2 – Tracer Codes Required for Positron Emission Tomography (PET Scans); effective 01-01-18; CMS Manual System – Change Request 10319, effective 11-09-17	Automated	2/5/2019	Approved
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer).	0133 - PET Scans Paid without Tracer Codes for IDTF (Independent Diagnostic Testing Facility) Providers	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); 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; CMS Publication 100-04; Chapter 13, § 60.3.2 – Tracer Codes Required for Positron Emission Tomography (PET Scans); effective 01-01-18; CMS Manual System – Change Request 10319, effective 11-09-17	Automated	2/5/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for Cryosurgery of the Prostate are not deemed to be medically necessary based on the guidelines outlined in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, § 230.9).	0134 - Cryosurgery of the Prostate Medical Necessity	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.986 Good Cause for Reopening; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; CMS National Coverage Determinations Manual (NCD), Pub 100-03, Part 4, §230.9 Cryosurgery of Prostate (Rev. 1, 10-03-03).; CMS Claims Processing Manual, Pub 100-04, Ch. 32, §180 Cryosurgery of the Prostate Gland (Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07).	Complex	2/5/2019	Approved
Claims for Cryosurgery of the Prostate are not deemed to be medically necessary based on the guidelines outlined in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, § 230.9).	0134 - Cryosurgery of the Prostate Medical Necessity	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.986 Good Cause for Reopening; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; CMS National Coverage Determinations Manual (NCD), Pub 100-03, Part 4, §230.9 Cryosurgery of Prostate (Rev. 1, 10-03-03).; CMS Claims Processing Manual, Pub 100-04, Ch. 32, §180 Cryosurgery of the Prostate Gland (Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07).	Complex	2/5/2019	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 - Medical Necessity Cardiac Rehabilitation	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act § 1862 (a)(1)(A); 2. Social Security Act § 1833 (e); 3. Social Security Act § 1861 (s)(2)(CC)(e); 4. 42 C.F.R. §§ 410.49; 5. CMS National Coverage Determinations (NCD), Pub. 100-03, Section 20.10.1, 20.31, 20.31.1, 20.31.2, and 20.31.3; 6. CMS Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 232; 7. CMS Claim Processing Manual, Pub. 100-04, Chapter 32, Section 140; 8. CMS Transmittal R1974CP, Issued 5/21/2010, Implementation Date 10/4/2010; 9. CMS Transmittal R126BP, Issued 5/21/2010, Implementation Date 10/4/2010; 10. CMS Transmittal R339PI, Issued 5/21/2010, Implementation Date 10/4/2010; 11. Palmetto LCD L34412 Cardiac Rehabilitation, Effective Date 10/1/2015; 12. Palmetto LCA A53775 Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Supplemental Instruction Article, Effective Date 10/1/2015	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 - Medical Necessity Cardiac Rehabilitation	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act § 1862 (a)(1)(A); 2. Social Security Act § 1833 (e); 3. Social Security Act § 1861 (s)(2)(CC)(e); 4. 42 C.F.R. §§ 410.49; 5. CMS National Coverage Determinations (NCD), Pub. 100-03, Section 20.10.1, 20.31, 20.31.1, 20.31.2, and 20.31.3; 6. CMS Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 232; 7. CMS Claim Processing Manual, Pub. 100-04, Chapter 32, Section 140; 8. CMS Transmittal R1974CP, Issued 5/21/2010, Implementation Date 10/4/2010; 9. CMS Transmittal R126BP, Issued 5/21/2010, Implementation Date 10/4/2010; 10. CMS Transmittal R339PI, Issued 5/21/2010, Implementation Date 10/4/2010; 11. Palmetto LCD L34412 Cardiac Rehabilitation, Effective Date 10/1/2015; 12. Palmetto LCA A53775 Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Supplemental Instruction Article, Effective Date 10/1/2015	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 - Medical Necessity and Coding of Chest X-Rays	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. CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §§80.4-80.4.4, Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 9. CMS Manual System, Pub, 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.6.1, Definitions; 10. CMS Manual System, Pub. 100-04, Program Integrity Manual, Chapter 3 §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 11. CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.3, Diagnoses Code Requirement; 12. CPT 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 - Medical Necessity and Coding of Chest X-Rays	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. CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §§80.4-80.4.4, Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 9. CMS Manual System, Pub, 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.6.1, Definitions; 10. CMS Manual System, Pub. 100-04, Program Integrity Manual, Chapter 3 §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 11. CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.3, Diagnoses Code Requirement; 12. CPT Manual	Complex	4/15/2019	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 (SNF) Consolidated Billing for Therapies	Physician/non-physician practitioner, Physical Therapist, Occupational Therapist, Speech-language Pathologist	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 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; 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
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 (SNF) Consolidated Billing for Therapies	Physician/non-physician practitioner, Physical Therapist, Occupational Therapist, Speech-language Pathologist	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 42 CFR §405.986- Good Cause for Reopening; Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 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; 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 - Medical Necessity Vertebroplasty and Kyphoplasty	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	Title XVIII of the Social Security Act (SSA): §§1833(e); 1862(a)(1)(A); 1862(a)(10). Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules; 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; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements 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; 42 CFR §405.986- Good Cause for reopening; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 General exclusion from coverage §§10 General exclusions from coverage; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 General exclusion from coverage §§20 Services not reasonable and Necessary; First Coast Service Options (FCSO) Local overage Determination (LCD) Vertebroplasty, Vertebral Augmentation, percutaneous L34976: Effective 10/01/2015; revised 4/17/18.; Novitas LCD L35130 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015; Revised 05/04/2017.; Palmetto LCD L33473 Vertebroplasty/Kyphoplasty: Effective 10/01/2015; Revised 08/09/2018.; WPS LCD L34592 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015; Revised 2/1/18.; NGS LCD L33569 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015.; Noridian LCD, Percutaneous Vertebral Augmentation, L34106, Effective 10/01/2015; Noridian LCD, Percutaneous Vertebral Augmentation, L34228, Effective 10/01/2015; CGS LCD, Vertebroplasty and Vertebral Augmentation, L34048, effective 10/01/2015; 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 - Medical Necessity Vertebroplasty and Kyphoplasty	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	Title XVIII of the Social Security Act (SSA): §§1833(e); 1862(a)(1)(A); 1862(a)(10). Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules; 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; Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services Definitions42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements 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; 42 CFR §405.986- Good Cause for reopening; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 General exclusion from coverage §§10 General exclusions from coverage; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 General exclusion from coverage §§20 Services not reasonable and Necessary; First Coast Service Options (FCSO) Local overage Determination (LCD) Vertebroplasty, Vertebral Augmentation, percutaneous L34976: Effective 10/01/2015; revised 4/17/18.; Novitas LCD L35130 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015; Revised 05/04/2017.; Palmetto LCD L33473 Vertebroplasty/Kyphoplasty: Effective 10/01/2015; Revised 08/09/2018.; WPS LCD L34592 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015; Revised 2/1/18.; NGS LCD L33569 Vertebroplasty, Vertebral Augmentation, percutaneous: Effective 10/01/2015.; Noridian LCD, Percutaneous Vertebral Augmentation, L34106, Effective 10/01/2015; Noridian LCD, Percutaneous Vertebral Augmentation, L34228, Effective 10/01/2015; CGS LCD, Vertebroplasty and Vertebral Augmentation, L34048, effective 10/01/2015; 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 - Medical Necessity Pulmonary Rehabilitation	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 C.F.R. §§ 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. CMS Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 231; 9. CMS Claim Processing Manual, Pub. 100-04, Chapter 32, Section 140; 10. CMS Transmittal R1966CP- Pulmonary Rehabilitation (PR) Services; Issued Date 5/7/2010, Implementation Date 10/4/2010; 11. Noridian LCA A52770 Pulmonary Rehabilitation; original effective date: 10/01/2015; Revision Date: 10/08/2018; 12. 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 - Medical Necessity Pulmonary Rehabilitation	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 C.F.R. §§ 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. CMS Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 231; 9. CMS Claim Processing Manual, Pub. 100-04, Chapter 32, Section 140; 10. CMS Transmittal R1966CP- Pulmonary Rehabilitation (PR) Services; Issued Date 5/7/2010, Implementation Date 10/4/2010; 11. Noridian LCA A52770 Pulmonary Rehabilitation; original effective date: 10/01/2015; Revision Date: 10/08/2018; 12. 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 - ASC Services During a Covered Part A SNF Stay	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. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 6 SNF 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; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 6 SNF 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; 5. 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; 6. SNF Consolidated Billing – Annual Updates for Part A MAC – 2015, 2016, 2017 and 2018 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; 7. SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2018-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2017-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2016-General-Explanations.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 - ASC Services During a Covered Part A SNF Stay	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. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 6 SNF 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; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 6 SNF 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; 5. 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; 6. SNF Consolidated Billing – Annual Updates for Part A MAC – 2015, 2016, 2017 and 2018 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; 7. SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2018-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2017-General-Explanation.pdf https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2016-General-Explanations.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 (ERFA and EVLT) for Lower Extremity Varicose Veins	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 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial 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. CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 1/1/2018; 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 1/1/2018; 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 5/17/2018; 12. Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 11/12/2018; 13. WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 10/01/2018;	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 (ERFA and EVLT) for Lower Extremity Varicose Veins	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 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial 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. CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 1/1/2018; 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 1/1/2018; 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 5/17/2018; 12. Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 11/12/2018; 13. WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 10/01/2018;	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 - Unbundling of CT Scans	Professional Services (Physician/Non-Physician Practitioner) and 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. CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30 (H) (Most Extensive Procedures) and J. With/Without Procedures (Effective 10/1/03); 7. CMS Publication 100-04; Chapter 23, § 20.9.2 Fee Schedule Administration and Coding Requirements; 8. NCCI Policy Manual for Medicare Services Chapter 1 A; 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 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 - Unbundling of CT Scans	Professional Services (Physician/Non-Physician Practitioner) and 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. CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30 (H) (Most Extensive Procedures) and J. With/Without Procedures (Effective 10/1/03); 7. CMS Publication 100-04; Chapter 23, § 20.9.2 Fee Schedule Administration and Coding Requirements; 8. NCCI Policy Manual for Medicare Services Chapter 1 A; 9. CPT Manual year 2015 to current	Automated	3/27/2019	Approved
When a more extensive MRI is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI.	0147 - Unbundling of MRI Procedures	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 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial 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. CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30 (H) (Most Extensive Procedures) and J. With/Without Procedures (Effective 10/1/03); 7. CMS Publication 100-04; Chapter 23, § 20.9.2 Fee Schedule Administration and Coding Requirements; 8. NCCI Policy Manual for Medicare Services Chapter 1 A; 9. CPT Manual year 2015 to current	Automated	3/29/2019	Approved
When a more extensive MRI is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI.	0147 - Unbundling of MRI Procedures	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 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial 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. CMS Pub. 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physicians/Non-physician Practitioners), Sections 30 (H) (Most Extensive Procedures) and J. With/Without Procedures (Effective 10/1/03); 7. CMS Publication 100-04; Chapter 23, § 20.9.2 Fee Schedule Administration and Coding Requirements; 8. NCCI Policy Manual for Medicare Services Chapter 1 A; 9. CPT Manual year 2015 to current	Automated	3/29/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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	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; 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	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; 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
MMS 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. The physician who performs Mohs surgery carries dual responsibility and is acting as both surgeon and pathologist. Reviewers will determine if the additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314 is/are reported correctly according to the code descriptions.	0150 - Mohs Micrographic Surgery (MMS) 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. IOM, 100-08, 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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
MMS 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. The physician who performs Mohs surgery carries dual responsibility and is acting as both surgeon and pathologist. Reviewers will determine if the additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314 is/are reported correctly according to the code descriptions.	0150 - Mohs Micrographic Surgery (MMS) 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. IOM, 100-08, 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 - Complex Physicians/Non-physician practitioners Coding Validation	Professional Services (Physicians/ 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 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 Code of Federal Regulations (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. IOM, 100-04, Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners; 10. IOM, 100-04, Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements; 11. IOM, 100-08, Medicare Program Integrity Manual, Chapter 3 Verifying Potential Errors and Taking Corrective Actions §3.6.2.4 Coding Determinations; 12. American Medical Association (AMA), Current Procedural Terminology (CPT); 13. AMA, HCPCS Level II; 14. AMA CPT Assistant; 15. National Correct Coding Initiatives (NCCI) Policy Manual; 16. 1995 & 1997 Documentation Guidelines for Evaluation & Management Services;	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 - Complex Physicians/Non-physician practitioners Coding Validation	Professional Services (Physicians/ 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 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 Code of Federal Regulations (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. IOM, 100-04, Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners; 10. IOM, 100-04, Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements; 11. IOM, 100-08, Medicare Program Integrity Manual, Chapter 3 Verifying Potential Errors and Taking Corrective Actions §3.6.2.4 Coding Determinations; 12. American Medical Association (AMA), Current Procedural Terminology (CPT); 13. AMA, HCPCS Level II; 14. AMA CPT Assistant; 15. National Correct Coding Initiatives (NCCI) Policy Manual; 16. 1995 & 1997 Documentation Guidelines for Evaluation & Management Services;	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: 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;	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: 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;	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 (ALS) and Basic Life Support (BLS): Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA) § 1833 (e) Payment of Benefits; 2. SSA 1862(a)(1) states that no payment may be made under part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 3. SSA 1861(s)(7) defines ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in the regulations; 4. SSA 1834(l) (10)-(16) Fee Schedule for Ambulance 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 §424.5 (a)(6) Basic Conditions; Sufficient Information; 8. 42 CFR 410.40 (b) Coverage of ambulance services; Levels of service; 9. 42 CFR 410.40 (d)(1) Coverage of ambulance services; Medical necessity requirements; 10. 42 CFR 410.40 (d)(2) Special rule for nonemergency, scheduled, repetitive ambulance services; 11. 42 CFR 410.40 (d)(3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis; 12. 42 CFR 410.41 (c) Requirements for ambulance suppliers; Billing and reporting requirements; 13. 42 CFR 414.605 Definitions; 14. 42 CFR 414.610 Basis of Payment; 15. 42 CFR 411.15 (k)(1) Particular Services Excluded from Coverage, Any Services not Reasonable and Necessary; 16. 42 CFR 424.36 Signature Requirements and 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 17. IOM, 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 10, §10 Ambulance Service; §20 Coverage Guidelines for Ambulance Service Claims; §30.1.1 Ground Ambulance Services, Emergency Response, Definition;	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 (ALS) and Basic Life Support (BLS): Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA) § 1833 (e) Payment of Benefits; 2. SSA 1862(a)(1) states that no payment may be made under part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 3. SSA 1861(s)(7) defines ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in the regulations; 4. SSA 1834(l) (10)-(16) Fee Schedule for Ambulance 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 §424.5 (a)(6) Basic Conditions; Sufficient Information; 8. 42 CFR 410.40 (b) Coverage of ambulance services; Levels of service; 9. 42 CFR 410.40 (d)(1) Coverage of ambulance services; Medical necessity requirements; 10. 42 CFR 410.40 (d)(2) Special rule for nonemergency, scheduled, repetitive ambulance services; 11. 42 CFR 410.40 (d)(3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis; 12. 42 CFR 410.41 (c) Requirements for ambulance suppliers; Billing and reporting requirements; 13. 42 CFR 414.605 Definitions; 14. 42 CFR 414.610 Basis of Payment; 15. 42 CFR 411.15 (k)(1) Particular Services Excluded from Coverage, Any Services not Reasonable and Necessary; 16. 42 CFR 424.36 Signature Requirements and 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 17. IOM, 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 10, §10 Ambulance Service; §20 Coverage Guidelines for Ambulance Service Claims; §30.1.1 Ground Ambulance Services, Emergency Response, Definition;	Complex	5/22/2019	Approved
Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers. Documentation will be reviewed to determine if the billed procedures meets Medicare coverage criteria and applicable coding guidelines for the use of modifier 73.	0157 - Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	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
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
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 lower allowed amount CPT Code will be recovered as an overpayment. Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter.	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
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 lower allowed amount CPT Code will be recovered as an overpayment. Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter.	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