Cotiviti Approved Issues List as of June 30, 2022

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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Coding changes may result in a partial overpayment or under payment. Non-receipt of records will result in a full overpayment. Review of Length of Stay and Clinical Validation is not permitted.	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Program Integrity Manual, CMS Publication 100-08; Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review; 9. CMS Quality Improvement Organization (QIO) Manual, Chapter 4- Case Review, Section 4130- DRG Validation Review ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 10. ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 11. Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017	Approved
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Coding changes may result in a partial overpayment or under payment. Non-receipt of records will result in a full overpayment. Review of Length of Stay and Clinical Validation is not permitted.	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Program Integrity Manual, CMS Publication 100-08; Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review; 9. CMS Quality Improvement Organization (QIO) Manual, Chapter 4- Case Review, Section 4130- DRG Validation Review ICD-10 CM Official Guidelines for Coding and Reporting, and Addendums; 10. ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 11. Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017	Approved

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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; 6. Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; 7. First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Revised 08/06/2019; Retired 8/13/2020; 8. First Coast Service Options, Inc., LCA A56508 - Billing and Coding: Sacral Neuromodulation, Effective 01/08/2019, Retired 08/13/2020; 9. Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 04/18/2019; Retired 8/13/2020; 10. Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 11. Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 12. CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; Revised 03/04/2021; 13. CPT Assistant, December 2012, Volume 22, Issue 12, page 14- Surgery: Nervous System, Placement Permanent Neurostimulator Electrode Array with Implant of Pulse Generator	Complex	1/23/2017	Approved
Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. National Coverage Determination 230.18- Sacral Nerve Stimulation for Urinary Incontinence, Effective 1/1/2002; 6. Medicare Claims Processing, Chapter 32- Billing Requirements for Special Services, Section 40- Sacral Nerve Stimulation; 7. First Coast Service Options, Inc., LCD L36296- Sacral Neuromodulation, Effective 10/1/2015; Revised 08/06/2019; Retired 8/13/2020; 8. First Coast Service Options, Inc., LCA A56508 - Billing and Coding: Sacral Neuromodulation, Effective 01/08/2019, Retired 08/13/2020; 9. Novitas Solutions, Inc., LCD L35449- Sacral Nerve Stimulation, Effective 10/1/2015; Revised 04/18/2019; Retired 8/13/2020; 10. Noridian Healthcare Solutions, LLC, LCA A53017- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 11. Noridian Healthcare Solutions, LLC, LCA A53359- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 10/1/2015; Revised 01/01/2020; 12. CGS Administrators, LLC, LCA A55835- Sacral Nerve Stimulation for Urinary and Fecal Incontinence, Effective 02/01/2018; Revised 03/04/2021; 13. CPT Assistant, December 2012, Volume 22, Issue 12, page 14- Surgery: Nervous System, Placement Permanent Neurostimulator Electrode Array with Implant of Pulse Generator	Complex	1/23/2017	Approved
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0004 - Skilled Nursing Facility: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	3 years prior to the ADR Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 Code of Federal Regulations 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations 405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations 409.30-409.36- Basic requirement; Level of care requirement; Criteria for skilled services and the need for skilled services; Examples for skilled nursing and rehabilitation services; Criteria for "daily basis"; Criteria for "practical matter"; Effect of discharge from posthospital SNF care; 6. 42 Code of Federal Regulations 424.20- Requirements for posthospital SNF care; 7. 42 Code of Federal Regulations 483.30 – Physician Services; 8. 42 Code of Federal Regulations 483.20- Resident assessment; 9. 42 Code of Federal Regulations 411.15(k)(1)- Particular services excluded from coverage; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40.4- Timing of Recertifications for Extended Care Services, §40.5- Delayed Certifications and Recertifications for Extended Care Services; 12. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services; §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills; §6.1.3- Bill Review Requirements; §6.1.4- Medical Review Process; §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 13. Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 14. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.1.3- Certification and Recertification of Need for Treatment and Therapy Plans of Care	Complex	5/5/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0004 - Skilled Nursing Facility: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	Skilled Nursing Facility (SNF)	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 Code of Federal Regulations 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations 405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations 409.30-409.36- Basic requirement; Level of care requirement; Criteria for skilled services and the need for skilled services; Examples for skilled nursing and rehabilitation services; Criteria for "daily basis"; Criteria for "practical matter"; Effect of discharge from posthospital SNF care; 6. 42 Code of Federal Regulations 424.20- Requirements for posthospital SNF care; 7. 42 Code of Federal Regulations 483.30 – Physician Services; 8. 42 Code of Federal Regulations 483.20- Resident assessment; 9. 42 Code of Federal Regulations 411.15(k)(1)- Particular services excluded from coverage; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40.4- Timing of Recertifications for Extended Care Services, §40.5- Delayed Certifications and Recertifications for Extended Care Services; 12. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services; §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills; §6.1.3- Bill Review Requirements; §6.1.4- Medical Review Process; §6.3- Medical Review of Certification and Recertification of Residents in SNFs; 13. Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 14. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.1.3- Certification and Recertification of Need for Treatment and Therapy Plans of Care	Complex	5/5/2017	Approved
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary and may result in an overpayment.	0008 - Bariatric Surgery: Medical Necessity and Documentation Requirements	Outpatient Hospital; Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; 8. First Coast LCD L33411- Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/01/2019; 9. Palmetto GBA LCD L34576- Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 10/1/2015; Revised 12/10/2020; 10. Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/01/2015; Revised 05/13/2021; 11. NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/01/2015; Revision 10/01/2020; 12. Noridian LCA A53026- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2021; 13. Noridian LCA A53028- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2020, Revision Ending 09/30/2021; 14. Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2020; 15. WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/01/2016; Revised: 10/01/2020; 16. Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/01/2020; Revision ending 09/30/2021; 17. First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; Revised 10/01/2020; 18. First Coast LCA A55930- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 3/15/2018; 19. First Coast LCA A56182- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 11/06/2018	Complex	1/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary and may result in an overpayment.	0008 - Bariatric Surgery: Medical Necessity and Documentation Requirements	Outpatient Hospital; Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; 8. First Coast LCD L33411- Surgical Management of Morbid Obesity; Effective 10/1/2015; Revised 10/01/2019; 9. Palmetto GBA LCD L34576- Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 10/1/2015; Revised 12/10/2020; 10. Novitas LCD L35022- Bariatric Surgical Management of Morbid Obesity; Effective 10/01/2015; Revised 05/13/2021; 11. NGS LCA A52447- Laparoscopic Sleeve Gastrectomy (LSG)- Medical Policy Article; Effective 10/01/2015; Revision 10/01/2020; 12. Noridian LCA A53026- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2021; 13. Noridian LCA A53028- Billing and Coding: Bariatric Surgery Coverage; Effective 10/01/2015; Revised 10/01/2020, Revision Ending 09/30/2021; 14. Novitas LCA A56422- Billing and Coding: Bariatric Surgical Management of Morbid Obesity: Effective 03/28/2019; Revised 10/01/2020; 15. WPS LCA A54923- Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity; Effective 3/01/2016; Revised: 10/01/2020; 16. Palmetto GBA LCA A56852- Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity; Effective 08/15/2019; Revised 10/01/2020; Revision ending 09/30/2021; 17. First Coast LCA A57145- Billing and Coding: Surgical Management of Morbid Obesity; Effective 10/03/2018; Revised 10/01/2020; 18. First Coast LCA A55930- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 3/15/2018; 19. First Coast LCA A56182- Surgical Management of Morbid Obesity Revision to the Part A and Part B LCD; Effective 11/06/2018	Complex	1/23/2017	Approved
Documentation will be reviewed to determine if Cardiac PET Scans meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0010 - Cardiac Positron Emission Tomography Scans: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - Florida, PR and VI ONLY	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 (e)(1)(B)- Advanced diagnostic imaging services defined; 4. Social Security Act (SSA), Title XVIII – Health Insurance for the Aged and Disabled, Section 1862 (a)(7) – Excludes routine physical examinations; 5. Social Security Act (SSA), Title XVIII – Definitions of Services, Institutions, Section 1861(s)(3) – Medical and Other Health Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, Section 220.6.1- PET for Perfusion of the Heart; 10. Medicare National Coverage Determination (NCD) Manual: Chapter 1, Part 4- Coverage Determinations, §220.6.8- FDG PET for Myocardial Viability; 11. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §50- Nuclear Medicine; 12. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60- Positron Emission Tomography (PET) Scans- General Information; 13. Medicare Claims Processing Manual, Chapter 13 – Radiology Services and Other Diagnostic Procedures, § 60.4 – PET Scans for imaging of the Perfusion of the Heart Using Rubidium 82 (RB 82); 14. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.9- Coverage of PET Scans for Myocardial Viability; 15. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.11- Coverage of PET Scans for Perfusion of the Heart Using Ammonia N-13; 16. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provisions in LCDs; 17. First Coast LCD L36209- Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET, Effective 10/01/2015; Retired 03/15/2020; 18. First Coast LCD L38396 - Cardiology – Non-emergent Outpatient Stress Testing, Effective 03/15/2020; Revised 4/25/2021; 19. First Coast LCA A56952 – Billing and Coding: Cardiology – Non-emergent Outpatient Stress Testing, Effective 03/15/2020, Revised 4/25/2021; 20. Annual American Medical Association: CPT Manual, Coding Guidelines; 21. Annual ICD-9-CM Manual, Coding Guidelines; 22. Annual HCPCS Manual, Coding Guidelines	Complex	1/24/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Inpatient	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; Issued: 12-02-05, Effective: 01-01-06, Implementation: 01-03-06; 9. AMA CPT Manual	Automated	1/29/2017	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Inpatient	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioners, § 30.6.14- Home Care and Domiciliary Care Visits; Issued: 12-02-05, Effective: 01-01-06, Implementation: 01-03-06; 9. AMA CPT Manual	Automated	1/29/2017	Approved
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay. Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Inpatient Psychiatric Stay Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 9. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4.1- Source of Admission for IPF PPS Claims for Payment of ED Adjustment; 10. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.10.1- General Rules	Automated	2/27/2017	Approved
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay. Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Inpatient Psychiatric Stay Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4- Emergency Department (ED) Adjustment; 9. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.6.4.1- Source of Admission for IPF PPS Claims for Payment of ED Adjustment; 10. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §190.10.1- General Rules	Automated	2/27/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Reviewers shall complete a complex medical review to determine if endomyocardial biopsy and right heart catheterization were performed as two distinct services. The review shall identify claims where modifier 59 or XU have been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together. Billed services that are not supported by medical record documentation will result in an overpayment.	0027 - Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 23- Fee Scheduled Administration and Coding Requirements, §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifiers 59 or -X{EPSU}; 9. NCCI Manuals, Chapter 1- General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 10. NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare; 11. CPT Manual	Complex	4/3/2017	Approved
Reviewers shall complete a complex medical review to determine if endomyocardial biopsy and right heart catheterization were performed as two distinct services. The review shall identify claims where modifier 59 or XU have been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together. Billed services that are not supported by medical record documentation will result in an overpayment.	0027 - Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 23- Fee Scheduled Administration and Coding Requirements, §20.9.1.1(B)- Instructions for Codes with Modifiers- Modifiers 59 or -X{EPSU}; 9. NCCI Manuals, Chapter 1- General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare; 10. NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare; 11. CPT Manual	Complex	4/3/2017	Approved
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied. HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) is a "one time" allowed Medicare benefit per beneficiary	0028 - Annual Wellness Visits: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	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) §410.15-Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 6. 42 Code of Federal Regulations (CFR) § 411.15- Particular services excluded from coverage (a) -Routine physical checkups such as Particular services excluded from coverage (1)- Examinations performed for a purpose; 7. 42 Code of Federal Regulations (CFR)§411.15- Particular services excluded from coverage (k)- Any services that are not reasonable and necessary (15)- In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in § 410.64 of this chapter; 8. Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 9. Medicare Claims Processing Manual, Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews	Automated	4/26/2017	Approved
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied. HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) is a "one time" allowed Medicare benefit per beneficiary	0028 - Annual Wellness Visits: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations (CFR) §410.15-Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 6. 42 Code of Federal Regulations (CFR) § 411.15- Particular services excluded from coverage (a) -Routine physical checkups such as Particular services excluded from coverage (1)- Examinations performed for a purpose; 7. 42 Code of Federal Regulations (CFR)§411.15- Particular services excluded from coverage (k)- Any services that are not reasonable and necessary (15)- In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in § 410.64 of this chapter; 8. Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 9. Medicare Claims Processing Manual, Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Hospital Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 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. 42 Code of Federal Regulations §424.5(a)(6)- Basic conditions; Sufficient information; 9. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), Effective: 01-01-11; 10. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231 - 99239), Effective: 04-01-08; 11. American Medical Association (AMA), Current Procedure Terminology 2007 to Present	Automated	3/23/2017	Approved
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Hospital Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 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. 42 Code of Federal Regulations §424.5(a)(6)- Basic conditions; Sufficient information; 9. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), Effective: 01-01-11; 10. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231 - 99239), Effective: 04-01-08; 11. American Medical Association (AMA), Current Procedure Terminology 2007 to Present	Automated	3/23/2017	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply. Hospital Care CPT codes 99221-99223, 99231-99233 and 99238-99239 will result in an overpayment and payment will be recovered.	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 2 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.D- Visits to Patients in Swing Beds	Automated	3/23/2017	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply. Hospital Care CPT codes 99221-99223, 99231-99233 and 99238-99239 will result in an overpayment and payment will be recovered.	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 2 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9.D- Visits to Patients in Swing Beds	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (s)(2)(FF)- Medical and Other Health Services- personalized prevention plan services (as defined in subsection (hhh)); 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 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, §§3.1- 3.6.6; 9. Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioners, § 30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201-99215), (A) Definition of New Patient for Selection of E/M Visit Code	Automated	3/23/2017	Approved
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (s)(2)(FF)- Medical and Other Health Services- personalized prevention plan services (as defined in subsection (hhh)); 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 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, §§3.1- 3.6.6; 9. Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioners, § 30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201-99215), (A) Definition of New Patient for Selection of E/M Visit Code	Automated	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting. Services billed incorrectly will result in an overpayment and will be recouped.	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6 ; 8. Medicare Claims Processing Manual, Chapter 3, §40.2- Determining Covered/Noncovered Days and Charges, §40.2.2- Charges to Beneficiaries of Part A Services, §140.3.1- Shared Systems and CWF Edits; 9. Medicare Claims Processing Manual, Chapter 4, §290.2.1- Revenue Code Reporting; 10. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6- - Evaluation and Management Service Codes - General (Codes 99201 - 99499), §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231-99239), §30.6.10- Consultation Services; 11. CMS Transmittal 10505, Change Request 12071 12/4/2020 Summary of Policies in the Calendar Year 2021 Medicare Physician Fee Schedule Final Rule, Office/Outpatient Evaluation & Management Visits; 12. AMA CPT Codebook	Automated	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting. Services billed incorrectly will result in an overpayment and will be recouped.	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6 ; 8. Medicare Claims Processing Manual, Chapter 3, §40.2- Determining Covered/Noncovered Days and Charges, §40.2.2- Charges to Beneficiaries of Part A Services, §140.3.1- Shared Systems and CWF Edits; 9. Medicare Claims Processing Manual, Chapter 4, §290.2.1- Revenue Code Reporting; 10. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6- - Evaluation and Management Service Codes - General (Codes 99201 - 99499), §30.6.9.1- Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services), §30.6.9.2- Subsequent Hospital Visit and Hospital Discharge Day Management (Codes 99231-99239), §30.6.10- Consultation Services; 11. CMS Transmittal 10505, Change Request 12071 12/4/2020 Summary of Policies in the Calendar Year 2021 Medicare Physician Fee Schedule Final Rule, Office/Outpatient Evaluation & Management Visits; 12. AMA CPT Codebook	Automated	3/23/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The subsequently billed new patient visit will be denied if another E/M procedure has been billed within the past 3 years.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a) (1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 8. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.7.A-Definition of New Patient for Selection of E/M Visit Code; 9. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 10. AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017	Approved
The subsequently billed new patient visit will be denied if another E/M procedure has been billed within the past 3 years.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a) (1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.1.1 - Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 8. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.7.A-Definition of New Patient for Selection of E/M Visit Code; 9. Medicare Claims Processing Manual, Chapter 12: Physicians/Non-physician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 10. AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017	Approved
Claims for CPT code 67228 (Treatment of extensive or progressive retinopathy), billed more frequently than once per eye within the global surgery period will be denied.	0047 - Panretinal (Scatter) Laser Photocoagulation: Excessive Frequency	Outpatient Hospital (OPH), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - NGS states only: IL, MN, WI	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1833(e) - Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 4. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions), §3.5.1- Reopening Claims and §3.6- Determinations Made During Review; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions), §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. CGS Administrators, Local Coverage Determination (LCD) L34064- Panretinal (Scatter) Laser Photocoagulation; Effective 10/01/2015; Revised 3/4/2021; 9. NGS, Local Coverage Determination (LCD) L33628- Panretinal (Scatter) Laser Photocoagulation; Effective 10/01/2015; Revised 9/19/2019; 10. CGS Administrators, Local Coverage Article A56594- Billing and Coding: Panretinal (Scatter) Laser Photocoagulation; Effective 10/03/2019; Revised 3/4/2021; 11. NGS, Local Coverage Article A56550- Billing and Coding: Panretinal (Scatter) Laser Photocoagulation; Effective 8/1/2019; Revised 9/19/2019	Automated	4/26/2017	Approved
Algorithm identifies all paid Ambulance Claims billed with any HCPCS codes listed in Appendix D with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNFs' Medicare Part A payments and is subject to consolidated billing. Therefore, Medicare Part B payments that suppliers receive for the ambulance transportation are overpayments.	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10.3.3- Separately Payable Ambulance Transport Under Part B Versus Patient Transportation That is Covered Under a Packaged Institutional Service; 9. Medicare Claims Processing Manual; Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §20.3.1- Ambulance Services; 10. Medicare Claims Processing Manual, Chapter 15- Ambulance, § 30.2.2- SNF Billing; 11. American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current	Automated	8/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Algorithm identifies all paid Ambulance Claims billed with any HCPCS codes listed in Appendix D with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNFs' Medicare Part A payments and is subject to consolidated billing. Therefore, Medicare Part B payments that suppliers receive for the ambulance transportation are overpayments.	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10.3.3- Separately Payable Ambulance Transport Under Part B Versus Patient Transportation That is Covered Under a Packaged Institutional Service; 9. Medicare Claims Processing Manual; Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §20.3.1- Ambulance Services; 10. Medicare Claims Processing Manual, Chapter 15- Ambulance, § 30.2.2- SNF Billing; 11. American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current	Automated	8/8/2017	Approved
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or Denied Primary Code	Professional Services (Physician/Non-Physician Practitioners); Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §70 Time Limitations for Filing Part A and Part B Claims; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40.8- Claims for Co-Surgeons and Team Surgeons; §40.9- Procedures Billed With Two or More Surgical Modifiers; 9. Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 10. Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	1/22/2021	Approved
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or Denied Primary Code	Professional Services (Physician/Non-Physician Practitioners); Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code; 7. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §70 Time Limitations for Filing Part A and Part B Claims; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40.8- Claims for Co-Surgeons and Team Surgeons; §40.9- Procedures Billed With Two or More Surgical Modifiers; 9. Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 10. Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	1/22/2021	Approved
Claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider, will be denied. Denied claims (or claim lines) will result in an overpayment and payment will be recovered.	0051 - Global versus Technical Component/Professional Component Reimbursements: Unbundling	Professional Services (Physician/Non-Physician Practitioner), Lab/Ambulance	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 8. Medicare Claims Processing Manual, Chapter 12 Physician/Non-physician Practitioners, §20.2 Relative Value Units (RVUs); 9. 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); 10. Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 12. Facility Outpatient Hospital Services and Practitioner Services MUE Tables, Link: Medically Unlikely Edits | CMS; 13. Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files, Link: PFS Relative Value Files | CMS	Automated	4/26/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider, will be denied. Denied claims (or claim lines) will result in an overpayment and payment will be recovered.	0051 - Global versus Technical Component/Professional Component Reimbursements: Unbundling	Professional Services (Physician/Non-Physician Practitioner), Lab/Ambulance	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), §120 (Detection of Duplicate Claims); 8. Medicare Claims Processing Manual, Chapter 12 Physician/Non-physician Practitioners, §20.2 Relative Value Units (RVUs); 9. 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); 10. Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients); 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 12. Facility Outpatient Hospital Services and Practitioner Services MUE Tables, Link: Medically Unlikely Edits | CMS; 13. Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files, Link: PFS Relative Value Files | CMS	Automated	4/26/2017	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility. The edits will capture improper payment of ambulance services during an inpatient hospital stay.	0054 - Ambulance Billed during Inpatient: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 9. Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4 CWF Editing of Ambulance Claims for Inpatients	Automated	6/20/2017	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility. The edits will capture improper payment of ambulance services during an inpatient hospital stay.	0054 - Ambulance Billed during Inpatient: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 9. Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4 CWF Editing of Ambulance Claims for Inpatients	Automated	6/20/2017	Approved
Claims with CPT inpatient hospital care evaluation and management (E/M) codes billed for services rendered to a patient residing in a skilled nursing facility (SNF), with no inpatient hospital facility claim for the same date of service, will be adjusted to equivalent CPT SNF E/M codes.	0056 - Evaluation and Management Services in Skilled Nursing Facilities: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7. American Medical Association (AMA) Current Terminology Manual (CPT), Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved
Claims with CPT inpatient hospital care evaluation and management (E/M) codes billed for services rendered to a patient residing in a skilled nursing facility (SNF), with no inpatient hospital facility claim for the same date of service, will be adjusted to equivalent CPT SNF E/M codes.	0056 - Evaluation and Management Services in Skilled Nursing Facilities: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physician/ Non Physician Practitioners, §30.6.13- Nursing Facility services; 7. American Medical Association (AMA) Current Terminology Manual (CPT), Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017	Approved

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 (CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter. Services billed incorrectly will result in an overpayment and will be recouped.	0057 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9. National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy	Complex	9/8/2017	Approved
Shoulder arthroscopy procedures include a limited debridement (CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter. Services billed incorrectly will result in an overpayment and will be recouped.	0057 - Arthroscopic Limited Shoulder Debridement: Incorrect Coding	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9. National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy	Complex	9/8/2017	Approved
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider may not exceed (1) in the units billed column per date of service.	0060 - Untimed Therapy: Excessive Units	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Rehabilitation Facility, Comprehensive Outpatient Rehabilitation Facility, Professional Services (Physician/Non-Physician Practitioner), Therapists in Private Practice	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual: Chapter 15- Covered Medical and Other Health Services, §220- Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance; §230- Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 9. Medicare Claims Processing Manual, Chapter 5- Part B Outpatient Rehabilitation and CORF Services, §10.3.2- Exceptions Process; §10.6- Functional Reporting; §20.2- Reporting of Service Units with HCPCS; 10. American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017	Approved
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider may not exceed (1) in the units billed column per date of service.	0060 - Untimed Therapy: Excessive Units	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Rehabilitation Facility, Comprehensive Outpatient Rehabilitation Facility, Professional Services (Physician/Non-Physician Practitioner), Therapists in Private Practice	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual: Chapter 15- Covered Medical and Other Health Services, §220- Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance; §230- Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology; 9. Medicare Claims Processing Manual, Chapter 5- Part B Outpatient Rehabilitation and CORF Services, §10.3.2- Exceptions Process; §10.6- Functional Reporting; §20.2- Reporting of Service Units with HCPCS; 10. American Medical Association (AMA), Current Procedure Terminology 2014 to current	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The Nursing Facility Services codes represent a "per day" service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service. Relevant CPT codes billed more than once per day will result in an overpayment.	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4. 42 Code of Federal Regulations §405.929- Post-Payment Review; 5. 42 Code of Federal Regulations §405.930- Failure to Respond to Additional Documentation Request; 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 Code of Federal Regulations §405.986- Good Cause for Reopening; 8. Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, § 30.6.13 Nursing Facility Services, (B) Visits to Comply with Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 11. Novitas Local Coverage Determination: Evaluation and Management Services Provided in a Nursing Facility (L35068), Effective for services performed on or after 10/01/15, Revised for services performed on or after 11/21/2019; 12. Novitas Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Effective 07/25/19, Revised 11/21/2019; 13. First Coast Local Coverage Determination: Evaluation and Management Services in a Nursing Facility (L36230), Effective for services performed on or after 11/15/15, Revised for services performed on or after 01/08/19; 14. First Coast Local Coverage Article: Billing and Coding: Evaluation and Management Services in a Nursing Facility (A57724), Effective 10/03/18	Automated	9/8/2017	Approved
The Nursing Facility Services codes represent a "per day" service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service. Relevant CPT codes billed more than once per day will result in an overpayment.	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4. 42 Code of Federal Regulations §405.929- Post-Payment Review; 5. 42 Code of Federal Regulations §405.930- Failure to Respond to Additional Documentation Request; 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 Code of Federal Regulations §405.986- Good Cause for Reopening; 8. Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, § 30.6.13 Nursing Facility Services, (B) Visits to Comply with Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. American Medical Association (AMA), Current Procedure Terminology Manual, 2014 to current; 11. Novitas Local Coverage Determination: Evaluation and Management Services Provided in a Nursing Facility (L35068), Effective for services performed on or after 10/01/15, Revised for services performed on or after 11/21/2019; 12. Novitas Local Coverage Article: Billing and Coding: Evaluation and Management Services Provided in a Nursing Facility (A56712), Effective 07/25/19, Revised 11/21/2019; 13. First Coast Local Coverage Determination: Evaluation and Management Services in a Nursing Facility (L36230), Effective for services performed on or after 11/15/15, Revised for services performed on or after 01/08/19; 14. First Coast Local Coverage Article: Billing and Coding: Evaluation and Management Services in a Nursing Facility (A57724), Effective 10/03/18	Automated	9/8/2017	Approved
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator "1" and/or "3" for TC component only. Services billed incorrectly will result in an overpayment and recoupment.	0062 - Radiology: Technical Component during Inpatient Stay	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §405.929- Post-Payment Review; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 13 Radiology Services and Other Diagnostic Procedures, § 20.2.1 Hospital and Skilled Nursing Facility (SNF) Patients; 9. Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, § 10.7 – Type of Service	Automated	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator "1" and/or "3" for TC component only. Services billed incorrectly will result in an overpayment and recoupment.	0062 - Radiology: Technical Component during Inpatient Stay	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	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 §405.929- Post-Payment Review; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 13 Radiology Services and Other Diagnostic Procedures, § 20.2.1 Hospital and Skilled Nursing Facility (SNF) Patients; 9. Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set, § 10.7 – Type of Service	Automated	9/8/2017	Approved
Duplicate claims or line date of service items will be denied.	0064 - Facility Duplicate Claims	Inpatient Hospital; Outpatient Hospital; Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, §120.2- Detection of Duplicate Claims- Exact Duplicates	Automated	9/8/2017	Approved
Duplicate claims or line date of service items will be denied.	0064 - Facility Duplicate Claims	Inpatient Hospital; Outpatient Hospital; Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, §120.2- Detection of Duplicate Claims- Exact Duplicates	Automated	9/8/2017	Approved
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Services found to be not medically reasonable and necessary will be recouped and result in an overpayment.	0067 - Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements	Inpatient Hospital (IP); Inpatient Psychiatric Facility (IPF)	3 years prior to ADR Letter date	2 – all applicable states	1. Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 2. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as Secondary Payer; 3. Title XVIII of the Social Security Act (SSA), Section 1814(a)(2)(A) and (4)- Conditions of Limitations on Payment for Services; 4. Title XVIII of the Social Security Act (SSA), Section 1835(a)- Procedure for Payment of Claims of Providers of Services; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986 (a)- Establishing Good Cause for Reopening; 7. 42 CFR 409.62- Lifetime Maximum on Inpatient Psychiatric Care; 8. 42 CFR 412.404- Conditions for Payment under the Prospective Payment System for Inpatient Hospital Services of Psychiatric Facilities; 9. 42 CFR 424.14- Requirements for Inpatient Services of Inpatient Psychiatric Facilities; 10. 42 CFR 412.27(c)- Excluded Psychiatric Units: Additional Requirements; 11. 42 CFR 482.61- Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals; 12. 42 CFR §405.929- Post-Payment Review; 13. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 14. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 15. Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, Section 10.9- Inpatient Psychiatric Facility Services Certification and Recertification; 16. Medicare Benefit Policy Manual, Chapter 2- Inpatient Psychiatric Hospital Services, section 20- Admission Requirements; section 30- Medical Records Requirements; section 30.1- Development of Assessment/Diagnostic Data; section 30.2- Psychiatric Evaluation; section 30.2.1- Certification and Recertification Requirements; section 30.2.1.1- Certification; section 30.2.1.2- Recertification; section 30.2.1.3- Delayed/Lapsed Certification and Recertification; section 30.3- Treatment Plan; section 30.3.1- Individualized Treatment or Diagnostic Plan; section 30.3.2- Services Expected to Improve the Condition or for Purpose of Diagnosis; section 30.4 - Recording Progress; section 30.5- Discharge Planning and Discharge Summary; 17. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, section 190- Inpatient Psychiatric Facility Prospective Payment System (IPF PPS); 18. American Psychiatric Association Diagnostic and Statistical Manual, Text Revision, Fifth Edition; 19. ICD-10-CM codebook, Chapter 5- Mental, Behavioral and Neurodevelopmental disorders (F01-F99); 20. Inpatient Psychiatric Facility PPS FY Addendum A Final PPS Payment Updates https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools	Complex	9/8/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Services found to be not medically reasonable and necessary will be recouped and result in an overpayment.	0067 - Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements	Inpatient Hospital (IP); Inpatient Psychiatric Facility (IPF)	3 years prior to ADR Letter date	3 – all applicable states	1. Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 2. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as Secondary Payer; 3. Title XVIII of the Social Security Act (SSA), Section 1814(a)(2)(A) and (4)- Conditions of Limitations on Payment for Services; 4. Title XVIII of the Social Security Act (SSA), Section 1835(a)- Procedure for Payment of Claims of Providers of Services; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986 (a)- Establishing Good Cause for Reopening; 7. 42 CFR 409.62- Lifetime Maximum on Inpatient Psychiatric Care; 8. 42 CFR 412.404- Conditions for Payment under the Prospective Payment System for Inpatient Hospital Services of Psychiatric Facilities; 9. 42 CFR 424.14- Requirements for Inpatient Services of Inpatient Psychiatric Facilities; 10. 42 CFR 412.27(c)- Excluded Psychiatric Units: Additional Requirements; 11. 42 CFR 482.61- Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals; 12. 42 CFR §405.929- Post-Payment Review; 13. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 14. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 15. Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, Section 10.9- Inpatient Psychiatric Facility Services Certification and Recertification; 16. Medicare Benefit Policy Manual, Chapter 2- Inpatient Psychiatric Hospital Services, section 20- Admission Requirements; section 30- Medical Records Requirements; section 30.1- Development of Assessment/Diagnostic Data; section 30.2- Psychiatric Evaluation; section 30.2.1- Certification and Recertification Requirements; section 30.2.1.1- Certification; section 30.2.1.2- Recertification; section 30.2.1.3- Delayed/Lapsed Certification and Recertification; section 30.3- Treatment Plan; section 30.3.1- Individualized Treatment or Diagnostic Plan; section 30.3.2- Services Expected to Improve the Condition or for Purpose of Diagnosis; section 30.4 - Recording Progress; section 30.5- Discharge Planning and Discharge Summary; 17. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, section 190- Inpatient Psychiatric Facility Prospective Payment System (IPF PPS); 18. American Psychiatric Association Diagnostic and Statistical Manual, Text Revision, Fifth Edition; 19. ICD-10-CM codebook, Chapter 5- Mental, Behavioral and Neurodevelopmental disorders (F01-F99); 20. Inpatient Psychiatric Facility PPS FY Addendum A Final PPS Payment Updates https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools	Complex	9/8/2017	Approved
Hospital emergency department services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider (based on Tax ID and Provider Specialty Code).	0070 - Critical Care Billed on the Same Day as Emergency Room Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual: Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 7. Medicare Claims Processing Manual: Chapter 12- 30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Service); 8. Medicare Claims Processing Manual: Chapter 12- §30.6.12 (for dates prior to 5/9/2021) – Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292), Section (H)- Critical Care Services and Other Evaluation and Management Services Provided on Same Day and Section (I) – Critical Care Services Provided by Physicians in Group Practice(s); 9. CPT Manual	Automated	10/5/2017	Approved
Hospital emergency department services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider (based on Tax ID and Provider Specialty Code).	0070 - Critical Care Billed on the Same Day as Emergency Room Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual: Chapter 12- Physicians/Nonphysician Practitioners, §30.6.9 - Payment for Inpatient Hospital Visits – General; 7. Medicare Claims Processing Manual: Chapter 12- 30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Service); 8. Medicare Claims Processing Manual: Chapter 12- §30.6.12 (for dates prior to 5/9/2021) – Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292), Section (H)- Critical Care Services and Other Evaluation and Management Services Provided on Same Day and Section (I) – Critical Care Services Provided by Physicians in Group Practice(s); 9. CPT Manual	Automated	10/5/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected.	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B, TOB: 12x, 13x	3 years prior to the Informational Letter date	2 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicates- Submission of Institutional Claims; 9. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3 (B)- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Services; 10. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 11. Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §200.2- Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD); 12. Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; 13. Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; 14. Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 15. Medical Benefit Policy Manual, Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; 16. Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017	Approved
Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected.	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B, TOB: 12x, 13x	3 years prior to the Informational Letter date	3 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2 (A)- Exact Duplicates- Submission of Institutional Claims; 9. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3 (B)- Outpatient Services Treated as Inpatient Services- Preadmission Diagnostic Services; 10. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.5- Hospital Inpatient Bundling; 11. Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS), §200.2- Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD); 12. Medicare Claims Processing Manual, Chapter 15- Ambulance, §30.1.4- CWF Editing of Ambulance Claims for Inpatients; 13. Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §10.2- Billing Requirements; 14. Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 15. Medical Benefit Policy Manual, Chapter 6- Hospital Services Covered under Part B, §10.2- Other Circumstances in Which Payment Cannot Be Made Under Part A; 16. Medical Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims	Automated	10/5/2017	Approved
Medicare only pays for services that are reasonable and necessary for the setting billed. The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for beneficiaries who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. In order for IRF care to be considered reasonable and necessary, the documentation in the beneficiary's IRF medical record must demonstrate a reasonable expectation that CMS criteria, as defined in 42 C.F.R. §§412.600-622 and CMS Pub. 100-02, Ch. 1 section 110, was met at the time of admission to the IRF. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment	0073 - Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements	Inpatient Rehabilitation Facility; Inpatient	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. SSA, Title XVII- Health Insurance for the Aged and Disabled, §1834(m)(4)(F)- Telehealth Service; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR 405.986- Good Cause for Reopening; 8. 42 CFR 412.604(c)- Completion of patient assessment instrument; 9. 42 CFR 412.606(b)- Comprehensive Assessments; 10. 42 CFR 412.29- Classification criteria for payment under the inpatient rehabilitation facility prospective payment system; 11. 42 CFR 412.622- Basis of Payment, (a)- Method of Payment, (3)- IRF Coverage Criteria, (4)- Documentation, and (5)- Interdisciplinary Team Approach to Care; 12. 42 CFR 414.65- Payment for Telehealth Services; 13. Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered Under Part A, §110 – Inpatient Rehabilitation Facility (IRF) Services; 14. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.3- Documentation Requirements for Therapy Services; 15. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §140.3- Billing Requirements Under IRF PPS; 16. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6	Complex	10/4/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare only pays for services that are reasonable and necessary for the setting billed. The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for beneficiaries who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. In order for IRF care to be considered reasonable and necessary, the documentation in the beneficiary's IRF medical record must demonstrate a reasonable expectation that CMS criteria, as defined in 42 C.F.R. §§412.600-622 and CMS Pub. 100-02, Ch. 1 section 110, was met at the time of admission to the IRF. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment	0073 - Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements	Inpatient Rehabilitation Facility; Inpatient	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. SSA, Title XVII- Health Insurance for the Aged and Disabled, §1834(m)(4)(F)- Telehealth Service; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR 405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR 405.986- Good Cause for Reopening; 8. 42 CFR 412.604(c)- Completion of patient assessment instrument; 9. 42 CFR 412.606(b)- Comprehensive Assessments; 10. 42 CFR 412.29- Classification criteria for payment under the inpatient rehabilitation facility prospective payment system; 11. 42 CFR 412.622- Basis of Payment, (a)- Method of Payment, (3)- IRF Coverage Criteria, (4)- Documentation, and (5)- Interdisciplinary Team Approach to Care; 12. 42 CFR 414.65- Payment for Telehealth Services; 13. Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered Under Part A, §110 – Inpatient Rehabilitation Facility (IRF) Services; 14. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §220.3- Documentation Requirements for Therapy Services; 15. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §140.3- Billing Requirements Under IRF PPS; 16. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6	Complex	10/4/2018	Approved
Drugs and Biologicals are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that CPT/HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Effective January 1, 2017, when processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors shall require the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.	0074 - Drugs and Biologicals: Incorrect Units Billed	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, 10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services; §50.3- Incident to Requirements; §60.1.A- Commonly Furnished in Physicians' Offices; 10. Medicare Alpha-Numeric HCPCS File; 11. Annual American Medical Association: CPT Manual; 12. Annual HCPCS Level II Manual; 13. Medicare Part B Drug Average Sales Price; ASP Pricing File https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice; 14. U.S. National Library of Medicine DailyMed	Complex	12/21/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Drugs and Biologicals are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that CPT/HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Effective January 1, 2017, when processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors shall require the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.	0074 - Drugs and Biologicals: Incorrect Units Billed	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, 10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services; §50.3- Incident to Requirements; §60.1.A- Commonly Furnished in Physicians' Offices; 10. Medicare Alpha-Numeric HCPCS File; 11. Annual American Medical Association: CPT Manual; 12. Annual HCPCS Level II Manual; 13. Medicare Part B Drug Average Sales Price; ASP Pricing File https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice; 14. U.S. National Library of Medicine DailyMed	Complex	12/21/2017	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) has been paid within the previous eleven (11) whole months.	0077 - Annual Wellness Visit Billed Sooner Than Eleven Whole Months Following the Initial Preventive Physical Examination	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6. 42 CFR §411.15- Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 7. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(15), (16)- Any Services that are not Reasonable and Necessary, (15)-additional preventive services; (16) Annual Wellness Visit with PPE; 8. Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV)	Automated	1/9/2018	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) has been paid within the previous eleven (11) whole months.	0077 - Annual Wellness Visit Billed Sooner Than Eleven Whole Months Following the Initial Preventive Physical Examination	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6. 42 CFR §411.15- Particular Services Excluded from Coverage, (a)(1)- Routine Checkups; 7. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(15), (16)- Any Services that are not Reasonable and Necessary, (15)-additional preventive services; (16) Annual Wellness Visit with PPE; 8. Medicare Claims Processing Manual, Chapter 18- Preventive and Screening Services, §140- Annual Wellness Visit (AWV)	Automated	1/9/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Cardiac Pacemakers: Medical Necessity and Documentation Requirements	Outpatient Hospital (OP), Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare National Coverage Determinations (NCD), Chapter 1, Part 1, §20.8.3- Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. CGS Local Coverage Article A54961- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 05/01/2016; Revised 04/01/2021; 10. Cahaba Local Coverage Article A54949- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Retired 01/29/2018; 11. First Coast Local Coverage Article A54926- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 12. NGS Local Coverage Article A54909- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 4/15/2016; Revised 5/7/2020; 13. Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Revised 10/01/2019; 14. Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016, Revised 10/01/2019; 15. Novitas Local Coverage Article A54982- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 16. Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 05/06/2021; 17. WPS Local Coverage Article A54958- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/15/2016; Revised 08/26/2021; 18. Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018	Approved
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Cardiac Pacemakers: Medical Necessity and Documentation Requirements	Outpatient Hospital (OP), Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare National Coverage Determinations (NCD), Chapter 1, Part 1, §20.8.3- Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. CGS Local Coverage Article A54961- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 05/01/2016; Revised 04/01/2021; 10. Cahaba Local Coverage Article A54949- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Retired 01/29/2018; 11. First Coast Local Coverage Article A54926- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 12. NGS Local Coverage Article A54909- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 4/15/2016; Revised 5/7/2020; 13. Noridian Local Coverage Article A54929- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016; Revised 10/01/2019; 14. Noridian Local Coverage Article A54931- Single Chamber and Dual Chamber Permanent Cardiac Pacemakers- Coding and Billing; Effective 4/15/2016, Revised 10/01/2019; 15. Novitas Local Coverage Article A54982- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/1/2016; Revised 10/01/2019; 16. Palmetto Local Coverage Article A54831- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 01/13/2016; Revised 05/06/2021; 17. WPS Local Coverage Article A54958- Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers; Effective 5/15/2016; Revised 08/26/2021; 18. Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the finding is billed on the same claim line with units greater than 1 (for the same eye). Provider is entitled to payment for one eye and only a partial payment will be recovered.	0083 - Cataract Removal Excessive Units - Partial Denial	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital, 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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D Ophthalmology); 9. CGS LCA A56453 – Billing and Coding: Cataract Extraction, Effective 10/01/16; Revised 01/06/2022; 10. NGS LCA A56544 – Billing and Coding: Cataract Extraction, Effective 08/01/19; Revised 01/01/2020; 11. Novitas LCA A56615 – Billing and Coding: Cataract Extraction (including Complex Cataract Surgery), Effective 06/13/19; Revised 07/11/2021; 12. Palmetto LCA A56613 – Billing and Coding Cataract Surgery, Effective 06/13/19; Revised 01/01/2022; 13. Noridian LCA A57195 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; Revised 01/01/2022; 14. Noridian LCA A57196 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; Revised 01/01/2022; 15. Palmetto LCA A53047 – Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation, Effective 10/01/15; Revised 01/01/2022	Automated	3/14/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the finding is billed on the same claim line with units greater than 1 (for the same eye). Provider is entitled to payment for one eye and only a partial payment will be recovered.	0083 - Cataract Removal Excessive Units - Partial Denial	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital, 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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D Ophthalmology); 9. CGS LCA A56453 – Billing and Coding: Cataract Extraction, Effective 10/01/16; Revised 01/06/2022; 10. NGS LCA A56544 – Billing and Coding: Cataract Extraction, Effective 08/01/19; Revised 01/01/2020; 11. Novitas LCA A56615 – Billing and Coding: Cataract Extraction (including Complex Cataract Surgery), Effective 06/13/19; Revised 07/11/2021; 12. Palmetto LCA A56613 – Billing and Coding Cataract Surgery, Effective 06/13/19; Revised 01/01/2022; 13. Noridian LCA A57195 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; Revised 01/01/2022; 14. Noridian LCA A57196 – Billing and Coding: Cataract Surgery in Adults, Effective 10/01/19; Revised 01/01/2022; 15. Palmetto LCA A53047 – Billing and Coding: Complex Cataract Surgery: Appropriate Use and Documentation, Effective 10/01/15; Revised 01/01/2022	Automated	3/14/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye will be denied. This new issue indicates that findings are across claims, for the same eye, and the finding claim line is a Full recovery.	0084 - Cataract Removal: Duplicate Payment	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital, 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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 8. National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8- Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000 – 69999, Section D - Ophthalmology	Automated	3/14/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye will be denied. This new issue indicates that findings are across claims, for the same eye, and the finding claim line is a Full recovery.	0084 - Cataract Removal: Duplicate Payment	Professional Services (Physician/Non-Physician Practitioner), Outpatient Hospital, 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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 8. National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Chapter 8- Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000 – 69999, Section D - Ophthalmology	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services. Denied services will result in an overpayment.	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory, Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 8. Current Procedural Terminology Coding Book	Automated	3/13/2018	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services. Denied services will result in an overpayment.	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory, Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients; 8. Current Procedural Terminology Coding Book	Automated	3/13/2018	Approved
Hospital outpatient observation care (initial, subsequent and/or discharge management) rendered on the same date as a hospital inpatient admission by the same physician is not separately payable. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service	0086 - Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §424.5(a)(6)- Sufficient Information; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 9. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.8(D)- Admission to Inpatient Status Following Observation Care	Automated	3/14/2018	Approved
Hospital outpatient observation care (initial, subsequent and/or discharge management) rendered on the same date as a hospital inpatient admission by the same physician is not separately payable. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service	0086 - Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §424.5(a)(6)- Sufficient Information; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 9. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.6.8(D)- Admission to Inpatient Status Following Observation Care	Automated	3/14/2018	Approved
The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these laboratory services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system.	0087 - Laboratory Services for End-Stage Renal Disease Subject to Part B Consolidated Billing: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Benefit Policy Manual, Chapter 11- End Stage Renal Disease, §20.2- Laboratory Services; 9. Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 10. ESRD PPS Consolidated Billing- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018	Approved

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 - Laboratory Services for End-Stage Renal Disease Subject to Part B Consolidated Billing: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Benefit Policy Manual, Chapter 11- End Stage Renal Disease, §20.2- Laboratory Services; 9. Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.1- Lab Services; 10. ESRD PPS Consolidated Billing- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018	Approved
Covered ancillary items and services are not payable if there is no approved Ambulatory Surgical Center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §260- Ambulatory Surgical Center Services; 10. Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40- Payment for Ambulatory Surgery; 11. CMS Ambulatory Surgery Center Approved HCPCS Code and Payment Rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates	Automated	3/14/2018	Approved
Covered ancillary items and services are not payable if there is no approved Ambulatory Surgical Center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §260- Ambulatory Surgical Center Services; 10. Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40- Payment for Ambulatory Surgery; 11. CMS Ambulatory Surgery Center Approved HCPCS Code and Payment Rates available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates	Automated	3/14/2018	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - Clinical Social Worker during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section §1861(hh)- Clinical Social Worker, (hh)(2)- Clinical Social Worker Services; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §409.10(a)(4)- Included Services- Medical Social Services; 9. 42 CFR §410.73- Clinical Social Worker Services; 10. 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 13. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients	Automated	3/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - Clinical Social Worker during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section §1861(hh)- Clinical Social Worker, (hh)(2)- Clinical Social Worker Services; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §409.10(a)(4)- Included Services- Medical Social Services; 9. 42 CFR §410.73- Clinical Social Worker Services; 10. 42 CF §412.50(b)- Furnishing of Inpatient Hospital Services Directly or Under Arrangements; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §170- Clinical Social Worker (CSW) Services; 13. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §10.4- Payment of Nonphysician Services for Inpatients	Automated	3/14/2018	Approved
The technical component (TC) of lab/pathology services furnished to patients in an inpatient or outpatient hospital setting are not separately payable.	0090 - Laboratory/Pathology Technical Component for Inpatient or Outpatient Hospitals: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Laboratory; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 9. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements; Addendum – MPFSDB File Record Layout and Field Descriptions	Automated	4/4/2018	Approved
The technical component (TC) of lab/pathology services furnished to patients in an inpatient or outpatient hospital setting are not separately payable.	0090 - Laboratory/Pathology Technical Component for Inpatient or Outpatient Hospitals: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Laboratory; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 8. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 Physician/Non-Physician Practitioners, § 60 (B) Payment for Technical Component (TC) Services; 9. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements; Addendum – MPFSDB File Record Layout and Field Descriptions	Automated	4/4/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in an overpayment.	0091- Duplicate Claims: Professional Services	Part B Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 9. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicates, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 10. Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioner, §20.4.2- Site of Service Payment Differential; 11. Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes (POS) and Definitions	Automated	5/8/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in an overpayment.	0091- Duplicate Claims: Professional Services	Part B Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Financial Management Manual, Chapter 3- Overpayments, §10.2- Individual Overpayments; 9. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicates, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 10. Medicare Claims Processing Manual, Chapter 12- Physician/ Nonphysician Practitioner, §20.4.2- Site of Service Payment Differential; 11. Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes (POS) and Definitions	Automated	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcutaneous placement of a device.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	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, §§3.1- 3.6.6; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 1, §30.3- Acupuncture; 7. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.7.1- Assessing Patients Suitability for Electrical Nerve Stimulation Therapy; 8. Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L34328 Peripheral Nerve Stimulation Original Effective Date: 10/01/2015, Revised 12/01/2019; 9. Noridian Healthcare Solutions, LLC LCD L37360 Peripheral Nerve Stimulation Original Effective Date: 08/27/2018; Revised 12/01/19; 10. Wisconsin Physicians Service Insurance Corporation Local Coverage Article (LCA) A56062 Billing and Coding: Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT), Original Effective Date: 8/01/2018, Revised 07/30/2020; 11. Novitas Solutions, Inc., LCA A55240 Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device), Original Effective Date 08/11/2016, Revised 01/21/20; 12. Noridian Healthcare Solutions, LLC LCA A55530 Billing and Coding Peripheral Nerve Stimulation (JE) Original Effective Date: 8/27/2018, Revised 10/01/21; 13. Noridian Healthcare Solutions, LLC LCA A55531 Billing and Coding: Peripheral Nerve Stimulation (JF) Original Effective Date: 8/27/2018, Revised 10/01/21; 14. First Coast Service Options, Inc LCA A54794 Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) Original Effective Date: 12/24/2015, retired 1/14/2022; 15. American Medical Association Current Procedural Terminology Manual Healthcare Common Procedure Coding System, 2014 to current	Complex	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode when the record demonstrates either transcutaneous placement of a device or percutaneous placement without identification of the selected (peripheral or cranial) nerve.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 1, §30.3- Acupuncture; 7. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.7.1- Assessing Patients Suitability for Electrical Nerve Stimulation Therapy; 8. Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L34328 Peripheral Nerve Stimulation Original Effective Date: 10/01/2015, Revised 12/01/2019; 9. Noridian Healthcare Solutions, LLC LCD L37360 Peripheral Nerve Stimulation Original Effective Date: 08/27/2018; Revised 12/01/19; 10. Wisconsin Physicians Service Insurance Corporation Local Coverage Article (LCA) A56062 Billing and Coding: Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT), Original Effective Date: 8/01/2018, Revised 07/30/2020; 11. Novitas Solutions, Inc., LCA A55240 Billing and Coding: Auricular Peripheral Nerve Stimulation (Electro-Acupuncture Device), Original Effective Date 08/11/2016, Revised 01/21/20; 12. Noridian Healthcare Solutions, LLC LCA A55530 Billing and Coding Peripheral Nerve Stimulation (JE) Original Effective Date: 8/27/2018, Revised 10/01/21; 13. Noridian Healthcare Solutions, LLC LCA A55531 Billing and Coding: Peripheral Nerve Stimulation (JF) Original Effective Date: 8/27/2018, Revised 10/01/21; 14. First Coast Service Options, Inc LCA A54794 Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) Original Effective Date: 12/24/2015, retired 1/14/2022; 15. American Medical Association Current Procedural Terminology Manual Healthcare Common Procedure Coding System, 2014 to current	Complex	5/8/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcutaneous placement of a device.	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 10. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 11. Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 12. First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 13. NGS Local Coverage Article A56326- Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 14. Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 15. Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 16. Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 17. Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 18. WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	5/14/2018	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 10. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 11. Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 12. First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 13. NGS Local Coverage Article A56326- Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 14. Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 15. Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 16. Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 17. Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 18. WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	5/14/2018	Approved
Certain CPT codes for Part B Professional services for the same Beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care. These services are included in the critical care service and should not be reported separately.	0098 - Critical Care Professional Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, § 30.6.12 (J) – Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291-99292	Automated	6/18/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Certain CPT codes for Part B Professional services for the same Beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care. These services are included in the critical care service and should not be reported separately.	0098 - Critical Care Professional Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, § 30.6.12 (J) – Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291-99292	Automated	6/18/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services, listed in the SNF Consolidated Billing Table, Major Category I.F and V.A., provided to beneficiaries by the outpatient facility, in a Medicare covered Part A SNF stay, are included in a bundled prospective payment and are not separately payable. Payment for those services will be recouped as identified overpayments.	0099 - Skilled Nursing Facility Consolidated Billing: Unbundling	Outpatient Facility	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing; §§10-10.4- Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview; §§20- 20.6- Services Included in Part A PPS Payment Not Billable Separately by the SNF; 7. CMS SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	6/25/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services, listed in the SNF Consolidated Billing Table, Major Category I.F and V.A., provided to beneficiaries by the outpatient facility, in a Medicare covered Part A SNF stay, are included in a bundled prospective payment and are not separately payable. Payment for those services will be recouped as identified overpayments.	0099 - Skilled Nursing Facility Consolidated Billing: Unbundling	Outpatient Facility	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing; §§10-10.4- Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview; §§20- 20.6- Services Included in Part A PPS Payment Not Billable Separately by the SNF; 7. CMS SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	6/25/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied.	0100 - Add-On Code Paid without Primary Code and/or Denied Primary Code: Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code (Rev. 10742, Issued: 05/03/21, Effective: 05/09/21, Implementation: 05/09/21); 7. Medicare Claims Processing Manual Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 8. Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9. Medicare Claims Processing Manual, Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 10. National Correct Coding Initiative, Add-on Code Edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	6/20/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied.	0100 - Add-On Code Paid without Primary Code and/or Denied Primary Code: Clinical Laboratory	Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 12- physicians/Nonphysician Practitioners, §30.D- Coding Services Supplemental to Principal Procedure (Add-On Codes) Code (Rev. 10742, Issued: 05/03/21, Effective: 05/09/21, Implementation: 05/09/21); 7. Medicare Claims Processing Manual Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; 8. Medicare Claims Processing Manual, Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; 9. Medicare Claims Processing Manual, Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 10. National Correct Coding Initiative, Add-on Code Edits https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits	Automated	6/20/2018	Approved
APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the APC by reviewing the billed services affecting or potentially affecting APC reimbursement.	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §414- Payment for Part B Medical and Other Health Services; 4. 42 CFR §419- Prospective Payment System for Hospital Outpatient Department Services; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS) §§10.1- 10.5, 20, 40-61, 100, 120, 150-240, 270, and 300; 10. American Medical Association (AMA), Current Procedure Terminology, Coding and Payment, APC Payment Book, APC Grouping Logic: Comprehensive APCs (SI=J1), APCs for Hospital Part B services paid through a comprehensive APC (SI = J1), Procedure or Service, Not Discounted When Multiple (SI=S), Procedure or Service, Multiple Reduction Applies (SI = T), and Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals (SI=K); 11. AMA CPT Assistant; 12. National Correct Coding Initiative Policy Manual; 13. Integrated Outpatient Code Editor (I/OCE) CMS Specifications Addendum J-: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V22.3. R1 Effective October 2021), Section 5.2: Computation of Discounting Fraction (OPPS only), Section 5.6 Composite APC Processing and Section 5.11 Pass-Through Drugs and Biologicals Processing (OPPS Only, V22.3.R.1); 14. CMS Hospital Outpatient PPS, Addendum B Updates, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	Complex	7/26/2018	Approved
APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the APC by reviewing the billed services affecting or potentially affecting APC reimbursement.	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §414- Payment for Part B Medical and Other Health Services; 4. 42 CFR §419- Prospective Payment System for Hospital Outpatient Department Services; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.6.2.4- Coding Determinations; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Claims Processing Manual, Chapter 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS) §§10.1- 10.5, 20, 40-61, 100, 120, 150-240, 270, and 300; 10. American Medical Association (AMA), Current Procedure Terminology, Coding and Payment, APC Payment Book, APC Grouping Logic: Comprehensive APCs (SI=J1), APCs for Hospital Part B services paid through a comprehensive APC (SI = J1), Procedure or Service, Not Discounted When Multiple (SI=S), Procedure or Service, Multiple Reduction Applies (SI = T), and Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals (SI=K); 11. AMA CPT Assistant; 12. National Correct Coding Initiative Policy Manual; 13. Integrated Outpatient Code Editor (I/OCE) CMS Specifications Addendum J-: Comprehensive APC Assignment Logic (OPPS Only, V16.0, Effective 01/01/2015 through V22.3. R1 Effective October 2021), Section 5.2: Computation of Discounting Fraction (OPPS only), Section 5.6 Composite APC Processing and Section 5.11 Pass-Through Drugs and Biologicals Processing (OPPS Only, V22.3.R.1); 14. CMS Hospital Outpatient PPS, Addendum B Updates, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	Complex	7/26/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also paid. ASC providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied. Denials will result in an overpayment.	0104 - Add-on Code Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual: Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; Chapter 12- Physicians/Nonphysician Practitioners, §30- Correct Coding Policy; Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 9. Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits; 10. AMA CPT Code book	Automated	7/24/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also paid. ASC providers paid for Add-On HCPCS/CPT codes without the required Primary code/or Denied Primary code will be denied. Denials will result in an overpayment.	0104 - Add-on Code Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual: Chapter 01- General Billing Requirements, §70- Time Limitations for Filing Part A and Part B Claims; Chapter 12- Physicians/Nonphysician Practitioners, §30- Correct Coding Policy; Chapter 16- Laboratory Services, §40.8- Date of Service (DOS) for Clinical Laboratory and Pathology Specimens; Chapter 29- Appeals of Claim Decisions, §240- Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals; 9. Add-on Code Edits, as updated by CMS- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits; 10. 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. Denied services will result in an overpayment.	0105 - Physician Services during Hospice Period: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 3. Title XVIII, §1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews, (b)- Timeframes and Requirements for 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 Code of Federal Regulations §405.986- Good Cause for Reopening; 8. 42 Code of Federal Regulations §418.400- Individual Liability for Coinsurance for Hospice Care; 9. 42 Code of Federal Regulations §418.402- Individual Liability for Services That are Not Considered Hospice Care; 10. Medicare Benefit Policy Manual, Chapter 9- - Coverage of Hospice Services Under Hospital Insurance, Section 10- Requirements; Section 40.1.3 - Physician Services; 11. Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims, Section 10 - Overview; Section 20.1 - Procedures for Hospice Election and Related Transactions; Section 30.3 - Data Required on the Institutional Claim to A/B MAC (HHH); Section 40.2- Processing Professional Claims for Hospice Beneficiaries; and Section 50- Billing and Payment for Services Unrelated to Terminal Illness; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6	Automated	8/14/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Physician services billed during an active hospice period should be paid by the Hospice provider if services are related to the hospice beneficiary's terminal condition or if a physician is employed or paid under arrangement by the beneficiary's hospice provider. Medicare should not be billed for either of the aforementioned scenarios. Denied services will result in an overpayment.	0105 - Physician Services during Hospice Period: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Title XVIII, §1833(e) of the Social Security Act- Payment of Benefits; 3. Title XVIII, §1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews, (b)- Timeframes and Requirements for 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 Code of Federal Regulations §405.986- Good Cause for Reopening; 8. 42 Code of Federal Regulations §418.400- Individual Liability for Coinsurance for Hospice Care; 9. 42 Code of Federal Regulations §418.402- Individual Liability for Services That are Not Considered Hospice Care; 10. Medicare Benefit Policy Manual, Chapter 9- - Coverage of Hospice Services Under Hospital Insurance, Section 10- Requirements; Section 40.1.3 - Physician Services; 11. Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims, Section 10 - Overview; Section 20.1 - Procedures for Hospice Election and Related Transactions; Section 30.3 - Data Required on the Institutional Claim to A/B MAC (HHH); Section 40.2- Processing Professional Claims for Hospice Beneficiaries; and Section 50- Billing and Payment for Services Unrelated to Terminal Illness; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6	Automated	8/14/2018	Approved
Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings. The rate, facility or nonfacility, which a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. Physician services identified by this audit and with a facility/non-facility rate differential will be repriced and may result in an overpayment or underpayment.	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual Chapter 12- Physician/Non-Physician Practitioners, §20.4.2- - Site of Service Payment Differential	Automated	9/11/2018	Approved
Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings. The rate, facility or nonfacility, which a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. Physician services identified by this audit and with a facility/non-facility rate differential will be repriced and may result in an overpayment or underpayment.	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual Chapter 12- Physician/Non-Physician Practitioners, §20.4.2- - Site of Service Payment Differential	Automated	9/11/2018	Approved
Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A stay are included in a bundled prospective payment made through the fiscal intermediary (FI) A/B Medicare Admin. Contractor (MAC) to the SNF. These bundled services are to be billed by the SNF to the FI A/B MAC in a consolidated bill. The consolidated billing requirements confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay. Unbundled services will be recouped and result in an overpayment.	0109 - Skilled Nursing Facility (SNF) Consolidated Billing Part B (Full)	Professional Services (Physician/Non-Physician Practitioner); Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	1. Title XVIII, §§1833(d) and (e) of the Social Security Act- Payment of Benefits; 2. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 8. SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/FileExplanation	Automated	9/20/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A stay are included in a bundled prospective payment made through the fiscal intermediary (FI) A/B Medicare Admin. Contractor (MAC) to the SNF. These bundled services are to be billed by the SNF to the FI A/B MAC in a consolidated bill. The consolidated billing requirements confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay. Unbundled services will be recouped and result in an overpayment.	0109 - Skilled Nursing Facility (SNF) Consolidated Billing Part B (Full)	Professional Services (Physician/Non-Physician Practitioner); Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	1. Title XVIII, §§1833(d) and (e) of the Social Security Act- Payment of Benefits; 2. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement; 8. SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/FileExplanation	Automated	9/20/2018	Approved
When a Part B CPT/HCPCS code listed on File 2 (Professional Components of Services to be Submitted with a 26 Modifier) is billed during a paid inpatient Part A SNF stay, without modifier 26, the Part B claim will be repriced with modifier 26 to reflect the professional component reduction. The overpayment is identified by the difference between the original paid Part B amount and the re-calculated paid amount based on modifier 26 pricing.	0110 - Skilled Nursing Facility Consolidated Billing: Part B – Use of Modifier 26, Professional Component	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement; 7. SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	9/20/2018	Approved
When a Part B CPT/HCPCS code listed on File 2 (Professional Components of Services to be Submitted with a 26 Modifier) is billed during a paid inpatient Part A SNF stay, without modifier 26, the Part B claim will be repriced with modifier 26 to reflect the professional component reduction. The overpayment is identified by the difference between the original paid Part B amount and the re-calculated paid amount based on modifier 26 pricing.	0110 - Skilled Nursing Facility Consolidated Billing: Part B – Use of Modifier 26, Professional Component	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), §20.1.1- Physician's Services and Other Professional Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement; 7. SNF Consolidated Billing - Part B Medicare Administrative Contractor (MAC) File Explanation - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling	Automated	9/20/2018	Approved
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary. Services that are determined to be not medically reasonable and necessary will result in an overpayment.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital (Medicare Part B only), Outpatient Hospital, Skilled Nursing Facility - Inpatient (Medicare Part B only)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); (a)(7)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.929- Post-Payment Review 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations §405.986 - Good Cause for Reopening; 7. 42 Code of Federal Regulations §410.32(a) - Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions; 8. 42 Code of Federal Regulations §411.15(k)(1) - Particular Services Excluded from Coverage 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests through §80.6.4- Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests; 11. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.4- Cardiovascular System (Codes 92950- 93799); 12. CGS LCD L34338- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 9/30/2021; 13. First Coast LCD L33768- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2019; 14. NGS LCD L33577- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2019; 15. Palmetto LCD L37379- Echocardiography; Effective 9/18/2017; Revised -06/10/2021; 16. CGS LCA A57306- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 9/26/2019; Revised 10/01/2021; 17. First Coast LCA A57182- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 10/03/2018; Revised 01/01/2022; 18. NGS LCA A56781- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 8/01/2019; Revised 01/01/2022; 19. Palmetto LCA A56625- Billing and Coding: Echocardiography; Effective 06/20/2019; Revised 01/01/2022; 20. American Medical Association (AMA), Current Procedural Terminology Manual, Coding Guidelines	Complex	9/28/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary. Services that are determined to be not medically reasonable and necessary will result in an overpayment.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital (Medicare Part B only), Outpatient Hospital, Skilled Nursing Facility - Inpatient (Medicare Part B only)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); (a)(7)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.929- Post-Payment Review 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations §405.986 - Good Cause for Reopening; 7. 42 Code of Federal Regulations §410.32(a) - Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions; 8. 42 Code of Federal Regulations §411.15(k)(1) - Particular Services Excluded from Coverage 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests through §80.6.4- Rules for Testing Facility Interpreting Physician to Furnish Different or Additional Tests; 11. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §30.4- Cardiovascular System (Codes 92950- 93799); 12. CGS LCD L34338- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 9/30/2021; 13. First Coast LCD L33768- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2019; 14. NGS LCD L33577- Transthoracic Echocardiography (TTE); Effective 10/01/2015; Revised 10/01/2019; 15. Palmetto LCD L37379- Echocardiography; Effective 9/18/2017; Revised -06/10/2021; 16. CGS LCA A57306- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 9/26/2019; Revised 10/01/2021; 17. First Coast LCA A57182- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 10/03/2018; Revised 01/01/2022; 18. NGS LCA A56781- Billing and Coding: Transthoracic Echocardiography (TTE); Effective 8/01/2019; Revised 01/01/2022; 19. Palmetto LCA A56625- Billing and Coding: Echocardiography; Effective 06/20/2019; Revised 01/01/2022; 20. American Medical Association (AMA), Current Procedural Terminology Manual, Coding Guidelines	Complex	9/28/2018	Approved
A Monthly Capitation Payment (MCP) is a payment made to physicians for most dialysis-related physician services furnished to Medicare End Stage Renal Disease (ESRD) patients on a monthly basis. The same monthly amount is paid to the physician for each patient supervised regardless of whether the patient dialyzes at home or as an outpatient in an approved ESRD facility. The claim/claim line with a single paid unit of 90957 or 90960 is the covered service. All additional claim(s)/claim line(s) of 90957-90962, are the overpayments and will be recovered in full.	0112 - Monthly Capitation Payment for End-Stage Renal Disease: 4 or More Visits per Month	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Reviews; 7. Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §140- Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis; §140.1- Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients); and §140.4- Controlling Claims Paid Under the Monthly Capitation Payment Method; 8. 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. The claim/claim line with a single paid unit of 90957 or 90960 is the covered service. All additional claim(s)/claim line(s) of 90957-90962, are the overpayments and will be recovered in full.	0112 - Monthly Capitation Payment for End-Stage Renal Disease: 4 or More Visits per Month	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Reviews; 7. Medicare Claims Processing Manual, Chapter 8- Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §140- Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis; §140.1- Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients); and §140.4- Controlling Claims Paid Under the Monthly Capitation Payment Method; 8. 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. Physician claims billed with a home-related place of service that overlaps an inpatient hospital stay will be denied.	0115 - Physician Claims with Place of Service Home Overlapping Inpatient Hospital Stay: Services Billed Not Rendered	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Reviews; 7. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicate Claims, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 8. Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes and Definitions; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §30- Physician Services	Automated	10/17/2018	Approved
Home Visits for physician services should not overlap an active Inpatient Stay. Providers cannot billed for services that are rendered. Physician claims billed with a home-related place of service that overlaps an inpatient hospital stay will be denied.	0115 - Physician Claims with Place of Service Home Overlapping Inpatient Hospital Stay: Services Billed Not Rendered	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Reviews; 7. Medicare Claims Processing Manual, Chapter 1- General Billing Requirements, §120.2(B)- Exact Duplicate Claims, Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers); 8. Medicare Claims Processing Manual, Chapter 26- Completing and Processing Form CMS-1500 Data Set, §10.5- Place of Service Codes and Definitions; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §30- Physician Services	Automated	10/17/2018	Approved
HCPCS Codes with a PC/TC Indicator of "1" and billed with either 26 or TC in any modifier field should be paid at either the technical component or the professional component rate based on the modifier billed. Overpayments occur when the applicable Medicare Physician Fee Schedule amount for Modifier TC and/or 26 are not applied. Findings will be the difference between the original Provider Paid Amount and the Re-Calculated Provider Paid Amount.	0116 - Modifiers TC and 26: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §50.6- Physician Fee Schedule Payment Policy Indicator File Record Layout; 9. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts 20 - Professional Component (PC)/Technical Component (TC) Indicator https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf; 10. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layout and Field Descriptions; MPFSDB File Record Layout for 2018 and prior may be found on the CMS website: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched	Automated	10/9/2018	Approved
HCPCS Codes with a PC/TC Indicator of "1" and billed with either 26 or TC in any modifier field should be paid at either the technical component or the professional component rate based on the modifier billed. Overpayments occur when the applicable Medicare Physician Fee Schedule amount for Modifier TC and/or 26 are not applied. Findings will be the difference between the original Provider Paid Amount and the Re-Calculated Provider Paid Amount.	0116 - Modifiers TC and 26: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §50.6- Physician Fee Schedule Payment Policy Indicator File Record Layout; 9. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts 20 - Professional Component (PC)/Technical Component (TC) Indicator https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf; 10. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layout and Field Descriptions; MPFSDB File Record Layout for 2018 and prior may be found on the CMS website: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched	Automated	10/9/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, at the same encounter, the limited debridement (code 29822) is not separately payable and Current Procedural Terminology (CPT) code 29822 will be denied. "Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure." Unbundled services will be denied and result in an overpayment.	0117 - Arthroscopic Limited Shoulder Debridement: Unbundling	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	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §411.15(k)(1)- Particular services excluded from coverage; 6. 42 CFR §424.5(a)(6)- Basic conditions- Sufficient information; 7. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	Automated	10/17/2018	Approved
If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, at the same encounter, the limited debridement (code 29822) is not separately payable and Current Procedural Terminology (CPT) code 29822 will be denied. "Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure." Unbundled services will be denied and result in an overpayment.	0117 - Arthroscopic Limited Shoulder Debridement: Unbundling	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	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §411.15(k)(1)- Particular services excluded from coverage; 6. 42 CFR §424.5(a)(6)- Basic conditions- Sufficient information; 7. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current	Automated	10/17/2018	Approved
Shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder. If another arthroscopy procedure is billed and paid for the same day, on the same shoulder, for the same beneficiary, on the same date of service, the extensive debridement (code 29823) is not separately payable and CPT code 29823 will be denied. Separate reporting of extensive debridement only applies to three CPT codes: 29824, 29827, and 29828. Unbundled services will be denied and result in an overpayment.	0118 - Arthroscopic Extensive Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital (For claims prior to 10/01/2017. After 10/01/2017, denial of 29823 made no change in APC.)	3 years prior to the Informational Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations §§411.15(k)(1)- Particular Services Excluded from Coverage, 424.5(a)(6)- Basic Conditions; 6. Medicare Program 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 Benefit Policy Manual , Chapter 16- General Exclusions from Coverage §20 –Services Not Reasonable and Necessary; 8. National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014- current; 9. 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. Unbundled services will be denied and result in an overpayment.	0118 - Arthroscopic Extensive Shoulder Debridement: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital (For claims prior to 10/01/2017. After 10/01/2017, denial of 29823 made no change in APC.)	3 years prior to the Informational Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations §§411.15(k)(1)- Particular Services Excluded from Coverage, 424.5(a)(6)- Basic Conditions; 6. Medicare Program 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 Benefit Policy Manual , Chapter 16- General Exclusions from Coverage §20 –Services Not Reasonable and Necessary; 8. National Correct Coding Initiative Policy Manual, Chapter 4, E, "Arthroscopy"- Effective January 1, 2014- current; 9. AMA CPT Codebook	Automated	10/16/2018	Approved
Lumbar epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of entry. These are termed the interlaminar, caudal, and transforaminal approaches. The procedures involve the injection of a solution containing local anesthetic with or without corticosteroids. In order to be considered medically necessary, they must meet certain indications and procedural requirements.	0119 - Transforaminal Epidural Steroid Injection: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 4. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Noridian Healthcare Solutions, LLC (JF), Local Coverage Determination; L34980 Lumbar Epidural Injections; Effective: 10/01/2015; Revised 10/01/2019; 7. Noridian Healthcare Solutions, LLC (JE), Local Coverage Determination; L34982 Lumbar Epidural injections; Effective: 10/01/2015; Revised 10/01/2019; 8. Noridian Healthcare Solutions, LLC (JE), Local Coverage Article; A57202 Billing and Coding: Lumbar Epidural Injections; Effective	Complex	10/31/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
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. If billed in excess of these limits, excess units of CPT codes 17000, 17003 and/or 17004 will be recovered.	0121 - Destruction of Premalignant Lesions: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions); 9. Palmetto GBA LCA A56346- Billing and Coding: Removal of Benign and Malignant Skin Lesions; Effective 01/01/2019; Revised 5/12/2022; 10. CGS Administrators, LLC, LCA A57044- Billing and Coding: Removal of Benign Skin Lesions; Effective 09/26/2019; Revised 7/29/2021; 11. NGS LCA A54602- Billing and Coding: Removal of Benign Skin Lesions; Effective 10/01/15; Revised 5/07/2020; 12. Novitas LCA A57113- Billing and Coding: Removal of Benign Skin Lesions; Effective 09/26/19; Revised 01/12/2022; 13. WPS, Local Coverage Article (LCA) A57482- Billing and Coding: Removal of Benign Skin Lesions; Effective 10/31/2019; Revised 10/28/2021	Automated	12/4/2018	Approved
Based on CPT Code descriptions, CPT Code 17000 may only be billed once per date of service; CPT Code 17003 may only be billed thirteen times per date of service, and CPT Code 17004 may only be billed once per date of service. If billed in excess of these limits, excess units of CPT codes 17000, 17003 and/or 17004 will be recovered.	0121 - Destruction of Premalignant Lesions: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. American Medical Association (AMA), Current Procedural Terminology (CPT) 2015 –current (Destruction, Benign or Premalignant Lesions); 9. Palmetto GBA LCA A56346- Billing and Coding: Removal of Benign and Malignant Skin Lesions; Effective 01/01/2019; Revised 5/12/2022; 10. CGS Administrators, LLC, LCA A57044- Billing and Coding: Removal of Benign Skin Lesions; Effective 09/26/2019; Revised 7/29/2021; 11. NGS LCA A54602- Billing and Coding: Removal of Benign Skin Lesions; Effective 10/01/15; Revised 5/07/2020; 12. Novitas LCA A57113- Billing and Coding: Removal of Benign Skin Lesions; Effective 09/26/19; Revised 01/12/2022; 13. WPS, Local Coverage Article (LCA) A57482- Billing and Coding: Removal of Benign Skin Lesions; Effective 10/31/2019; Revised 10/28/2021	Automated	12/4/2018	Approved
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. Identified unbundled services will be denied and may result in an overpayment.	0122 - Outpatient Service Related to Hospice Diagnosis: Unbundling	Part A Outpatient	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(dd)(1) Hospice Care; Hospice Program; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §418- Hospice Care; 7. CMS Claims Processing Manual 100-04, Chapter 11- Processing Hospice Claims, §10- Overview, §40.2- Processing Professional Claims for Hospice Beneficiaries, §50- Billing and Payment for Services Unrelated to Terminal Illness; 8. CMS Benefit Policy Manual 100-02, Chapter 9- Coverage of Hospice Services under Hospital Insurance, §10- Requirements, General; 9. CMS Medicare Program Integrity Manual 100-8, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 – No Response or Insufficient Response to Additional Documentation Requests	Automated	11/29/2018	Approved
Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. Identified unbundled services will be denied and may result in an overpayment.	0122 - Outpatient Service Related to Hospice Diagnosis: Unbundling	Part A Outpatient	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(dd)(1) Hospice Care; Hospice Program; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §418- Hospice Care; 7. CMS Claims Processing Manual 100-04, Chapter 11- Processing Hospice Claims, §10- Overview, §40.2- Processing Professional Claims for Hospice Beneficiaries, §50- Billing and Payment for Services Unrelated to Terminal Illness; 8. CMS Benefit Policy Manual 100-02, Chapter 9- Coverage of Hospice Services under Hospital Insurance, §10- Requirements, General; 9. CMS Medicare Program Integrity Manual 100-8, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 – No Response or Insufficient Response to Additional Documentation Requests	Automated	11/29/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When billed on the same date of service as an inpatient hospital claim, the Technical Component (TC) of diagnostics is not payable to the Part B provider. The technical component is performed by the facility while a patient is in a covered Part A Inpatient Stay. Incorrect billing of the technical component will be denied.	0123 - Technical Component of Diagnostic Procedures During Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum-MPFSDB File Layouts, 2011-2018 File Layout; 6. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, §30 Services Paid Under the Medicare Physician's Fee Schedule; 7. Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, §30.1 Provider-Based Physician Services; 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	Automated	12/11/2018	Approved
When billed on the same date of service as an inpatient hospital claim, the Technical Component (TC) of diagnostics is not payable to the Part B provider. The technical component is performed by the facility while a patient is in a covered Part A Inpatient Stay. Incorrect billing of the technical component will be denied.	0123 - Technical Component of Diagnostic Procedures During Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Title XVIII, §1862(a)(1)(A) of the Social Security Act- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, Addendum-MPFSDB File Layouts, 2011-2018 File Layout; 6. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, §30 Services Paid Under the Medicare Physician's Fee Schedule; 7. Medicare Benefit Policy Manual, Chapter 15 Covered Medical and Other Health Services, §30.1 Provider-Based Physician Services; 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	Automated	12/11/2018	Approved
HCPCS/CPT Codes with a PC/TC Indicator "7" in the Medicare Physician Fee Schedule Data Base payment may not be made if the service is provided to a hospital inpatient by a physical therapist, occupational therapist, or speech language therapist in private practice. Unbundled services will be denied and result in an overpayment.	0124 - Part B Therapies during Inpatient: Unbundling	Physical Therapist, Occupational Therapist, Speech Language Therapist	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, - Fee Schedule Administration and Coding Requirements; Addendum- MPFSDB File Record Layout and Field Descriptions, 2019. (For Historical Medicare Physician Fee Schedule Database (MPFSDB) Layouts 2001 – 2018, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Historical-MPFSDB-Layouts.pdf located on the CMS Physician Fee Schedule web page https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched	Automated	11/30/2018	Approved
HCPCS/CPT Codes with a PC/TC Indicator "7" in the Medicare Physician Fee Schedule Data Base payment may not be made if the service is provided to a hospital inpatient by a physical therapist, occupational therapist, or speech language therapist in private practice. Unbundled services will be denied and result in an overpayment.	0124 - Part B Therapies during Inpatient: Unbundling	Physical Therapist, Occupational Therapist, Speech Language Therapist	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 23, - Fee Schedule Administration and Coding Requirements; Addendum- MPFSDB File Record Layout and Field Descriptions, 2019. (For Historical Medicare Physician Fee Schedule Database (MPFSDB) Layouts 2001 – 2018, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Historical-MPFSDB-Layouts.pdf located on the CMS Physician Fee Schedule web page https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched	Automated	11/30/2018	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 Billed Same Day	Outpatient Facility; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 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; 9. AMA CPT Manual Endoscopy Section; 2015 to current; 10. National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI – Digestive System CPT Codes 4000 - 4999, §C – Endoscopic Services	Automated	11/14/2018	Approved
Surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code shall not be reported with a surgical endoscopy code. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered shall be reported	0126 - Endoscopy Procedures: Diagnostic and Surgical Billed Same Day	Outpatient Facility; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 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; 9. AMA CPT Manual Endoscopy Section; 2015 to current; 10. National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VI – Digestive System CPT Codes 4000 - 4999, §C – Endoscopic Services	Automated	11/14/2018	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere pressure. The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30) days of treatment with standard wound therapy and must be used in addition to standard wound care. Medical records will be reviewed to determine if Hyperbaric Oxygen Therapy (HBOT) for diabetic wounds is medically necessary according to Medicare coverage indications. HBOT for diabetic wounds that do not meet Medicare guidelines will result in an improper payment.	0129 - Hyperbaric Oxygen Therapy for Diabetic Wounds: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6. 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); 7. CMS National Coverage Determination Manual, Ch.1 Coverage determination, §20.29 Hyperbaric Oxygen Therapy, Effective 4/03/2017; Implemented 12/18/2017; 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. Novitas LCD L35021- Hyperbaric Oxygen (HBO) Therapy; Effective 10/01/2015; Revised 01/01/2020; Retired 8/27/2020; 10. Novitas LCA A56714 – Billing and Coding: Hyperbaric Oxygen (HBO) Therapy; Effective 07/25/19; Retired 08/27/20; 11. First Coast Service LCD L36504- Hyperbaric Oxygen (HBO) Therapy; Effective 04/11/2016; Revised 11/28/2019; Retired 08/27/2020; 12. First Coast LCA A57800 – Billing and Coding: Hyperbaric Oxygen (HBO) Therapy; Effective 10/03/18; Retired 08/27/20; 13. Annual American Medical Association CPT Manual, Coding Guidelines	Complex	1/30/2019	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber breathing 100% oxygen (O2) at greater than one atmosphere pressure. The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least thirty (30) days of treatment with standard wound therapy and must be used in addition to standard wound care. Medical records will be reviewed to determine if Hyperbaric Oxygen Therapy (HBOT) for diabetic wounds is medically necessary according to Medicare coverage indications. HBOT for diabetic wounds that do not meet Medicare guidelines will result in an improper payment.	0129 - Hyperbaric Oxygen Therapy for Diabetic Wounds: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6. 42 Code of Federal Regulations §411.15- Particular Services Excluded from Coverage, (k)- Any Services not Reasonable and Necessary, (1); 7. CMS National Coverage Determination Manual, Ch.1 Coverage determination, §20.29 Hyperbaric Oxygen Therapy, Effective 4/03/2017; Implemented 12/18/2017; 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. Novitas LCD L35021- Hyperbaric Oxygen (HBO) Therapy; Effective 10/01/2015; Revised 01/01/2020; Retired 8/27/2020; 10. Novitas LCA A56714 – Billing and Coding: Hyperbaric Oxygen (HBO) Therapy; Effective 07/25/19; Retired 08/27/20; 11. First Coast Service LCD L36504- Hyperbaric Oxygen (HBO) Therapy; Effective 04/11/2016; Revised 11/28/2019; Retired 08/27/2020; 12. First Coast LCA A57800 – Billing and Coding: Hyperbaric Oxygen (HBO) Therapy; Effective 10/03/18; Retired 08/27/20; 13. 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
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; Inpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII Health Insurance for the Aged and Disabled, Section 1862(a)(10); 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §411.15 Particular services excluded from coverage, (h), (k)(1); 7. 42 CFR §424.5 Basic conditions, (a)(6) Sufficient information; 8. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 9. 42 CFR §405.986- Good Cause for Reopening; 10. Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 11. Medicare Benefit Policy Manual, Ch. 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 12. Medicare Benefit Policy Manual, Ch. 16- General Exclusions from Coverage, §120 – Cosmetic Surgery; 13. Medicare Claims Processing Manual, Ch. 12 Physicians/Nonphysician Practitioners, §40.6 Claims for Multiple Surgeries (A) General; 14. National Correct Coding Initiative Policy Manual, Ch. 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 9, Revised 01/01/2022; 15. National Correct Coding Initiative Policy Manual, Ch. 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 8, Revised 01/01/2022; 16. National Correct Coding Initiative Policy Manual, Ch. 1 General Correct Coding Policies, E Modifiers and Modifier Indicators, Revised 01/01/2022; 17. National Correct Coding Initiative Policy Manual, Ch. 1 General Correct Coding Policies, E Modifiers and Modifier Indicators, Revised 01/01/2022; 18. FCSO Inc., Local Coverage Determination (LCD): L38914 – Cosmetic and Reconstructive Surgery; Effective 07/11/21; 19. Noridian (JE) LCD L35163: Plastic Surgery, Effective 10/1/2015; Revised 10/01/2019; 20. Noridian (JF) LCD L37020: Plastic Surgery, Effective 10/10/2017; Revised 10/01/2019; 21. Novitas LCD L35090: Cosmetic and Reconstructive Surgery, Effective 10/1/2015; Revised 07/11/2021; 22. Palmetto GBA L33428: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 07/29/2021; 23. WPS L34698: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 01/01/2021; Retired 11/13/2021; 24. WPS L39051: Cosmetic and Reconstructive Surgery, Effective 11/14/2021; 15. FCSO Inc., Local Coverage Article (LCA): A58573 – Billing and Coding: Cosmetic and Reconstructive Surgery: Effective 07/11/2021; 26. Noridian (JE) LCA A57221: Billing and Coding: Plastic Surgery, Effective 10/01/2019, Revised 01/01/2021; 27. Noridian (JF) LCA A57222: Billing and Coding: Plastic Surgery, Effective 10/01/2019, Revised 01/01/2021; 28.	Complex	2/13/2019	Approved
Panniculectomy billed for cosmetic purposes will not be deemed medically necessary. In addition, panniculectomy billed at the same time as an open abdominal surgery, or if is incidental to another procedure, is not separately coded per Coding Guidelines.	0130 - PPanniculectomy: Medical Necessity and Documentation Requirements	Outpatient Hospital; Inpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII Health Insurance for the Aged and Disabled, Section 1862(a)(10); 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §411.15 Particular services excluded from coverage, (h), (k)(1); 7. 42 CFR §424.5 Basic conditions, (a)(6) Sufficient information; 8. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 9. 42 CFR §405.986- Good Cause for Reopening; 10. Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 11. Medicare Benefit Policy Manual, Ch. 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 12. Medicare Benefit Policy Manual, Ch. 16- General Exclusions from Coverage, §120 – Cosmetic Surgery; 13. Medicare Claims Processing Manual, Ch. 12 Physicians/Nonphysician Practitioners, §40.6 Claims for Multiple Surgeries (A) General; 14. National Correct Coding Initiative Policy Manual, Ch. 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 9, Revised 01/01/2022; 15. National Correct Coding Initiative Policy Manual, Ch. 6 Surgery: Digestive System CPT Codes 40000 - 49999, E Abdominal Procedures, 8, Revised 01/01/2022; 16. National Correct Coding Initiative Policy Manual, Ch. 1 General Correct Coding Policies, E Modifiers and Modifier Indicators, Revised 01/01/2022; 17. National Correct Coding Initiative Policy Manual, Ch. 1 General Correct Coding Policies, E Modifiers and Modifier Indicators, Revised 01/01/2022; 18. FCSO Inc., Local Coverage Determination (LCD): L38914 – Cosmetic and Reconstructive Surgery; Effective 07/11/21; 19. Noridian (JE) LCD L35163: Plastic Surgery, Effective 10/1/2015; Revised 10/01/2019; 20. Noridian (JF) LCD L37020: Plastic Surgery, Effective 10/10/2017; Revised 10/01/2019; 21. Novitas LCD L35090: Cosmetic and Reconstructive Surgery, Effective 10/1/2015; Revised 07/11/2021; 22. Palmetto GBA L33428: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 07/29/2021; 23. WPS L34698: Cosmetic and Reconstructive Surgery, Effective 10/01/2015; Revised 01/01/2021; Retired 11/13/2021; 24. WPS L39051: Cosmetic and Reconstructive Surgery, Effective 11/14/2021; 15. FCSO Inc., Local Coverage Article (LCA): A58573 – Billing and Coding: Cosmetic and Reconstructive Surgery: Effective 07/11/2021; 26. Noridian (JE) LCA A57221: Billing and Coding: Plastic Surgery, Effective 10/01/2019, Revised 01/01/2021; 27. Noridian (JF) LCA A57222: Billing and Coding: Plastic Surgery, Effective 10/01/2019, Revised 01/01/2021; 28.	Complex	2/13/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CMS will not pay for an emergency department visit or an office visit E&M service on the same day as a comprehensive nursing facility assessment when both the E&M service and the comprehensive nursing facility assessment are performed by the same physician, at a site other than the nursing facility. The E&M service is bundled into the comprehensive nursing facility assessment code. The E&M service is not separately payable.	0132 - Evaluation and Management Same Day as Admission to a Nursing Facility: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 Request, §3.3.1.3- Automated Reviews; 6. Medicare Claims Processing Manual: 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; 7. Medicare Claims Processing Manual: 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; 8. Medicare Claims Processing Manual: Chapter 12 -Physicians/Nonphysician Practitioners, §30.6.13 Nursing Facility Services, (A) Visits to Perform the Initial Comprehensive Assessment and Annual Assessments	Automated	2/5/2019	Approved
CMS will not pay for an emergency department visit or an office visit E&M service on the same day as a comprehensive nursing facility assessment when both the E&M service and the comprehensive nursing facility assessment are performed by the same physician, at a site other than the nursing facility. The E&M service is bundled into the comprehensive nursing facility assessment code. The E&M service is not separately payable.	0132 - Evaluation and Management Same Day as Admission to a Nursing Facility: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 Request, §3.3.1.3- Automated Reviews; 6. Medicare Claims Processing Manual: 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; 7. Medicare Claims Processing Manual: 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; 8. Medicare Claims Processing Manual: 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). Claims billed without the required Tracer HCPCS codes will be recovered as overpayments.	0133 - Positron Emission Tomography Scans Paid without Tracer Codes- Independent Diagnostic Testing Facility: Non-Allowable Service	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; effective 09/07/2021; 7. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.3.2- Tracer Codes Required for Positron Emission Tomography (PET Scans); Effective 09/07/2021	Automated	2/5/2019	Approved
All PET Scans require the use of radiopharmaceutical diagnostic imaging agent (tracer). Claims billed without the required Tracer HCPCS codes will be recovered as overpayments.	0133 - Positron Emission Tomography Scans Paid without Tracer Codes- Independent Diagnostic Testing Facility: Non-Allowable Service	Independent Diagnostic Testing Facility	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; effective 09/07/2021; 7. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §60.3.2- Tracer Codes Required for Positron Emission Tomography (PET Scans); Effective 09/07/2021	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 deemed to be medically necessary for the indications listed in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, §230.9). Documentation will be reviewed to determine whether Cryosurgery of the Prostate Gland services met Medicare coverage criteria and were reasonable and necessary.	0134 - Cryosurgery of the Prostate: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986 Good Cause for Reopening; Medicare National Coverage Determinations Manual (NCD), Chapter 1 Coverage Determinations, Part 4 (Sections 200-310.1), §230.9 Cryosurgery of Prostate; 5. Medicare Claims Processing Manual, Chapter 32 Billing Requirements for Special Services, §180 Cryosurgery of the Prostate Gland; 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	Complex	2/5/2019	Approved
Claims for Cryosurgery of the Prostate are deemed to be medically necessary for the indications listed in the Centers for Medicare and Medicaid National Coverage Determination Manual (Publication 100-03, Part 4, §230.9). Documentation will be reviewed to determine whether Cryosurgery of the Prostate Gland services met Medicare coverage criteria and were reasonable and necessary.	0134 - Cryosurgery of the Prostate: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986 Good Cause for Reopening; Medicare National Coverage Determinations Manual (NCD), Chapter 1 Coverage Determinations, Part 4 (Sections 200-310.1), §230.9 Cryosurgery of Prostate; 5. Medicare Claims Processing Manual, Chapter 32 Billing Requirements for Special Services, §180 Cryosurgery of the Prostate Gland; 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	Complex	2/5/2019	Approved
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meets Federal guidelines and Medicare coverage criteria.	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 1848(b)(5)- Treatment of Intensive Cardiac Rehabilitation Program; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(2)(CC), (DD)- Medical and Other Services- Cardiac Rehabilitation Program, Intensive Cardiac Rehabilitation Program; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(eee)(1), (4)(A)- Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §410.49 – Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1 –3.6.6; 12. Medicare National Coverage Determinations (NCD), Part 1 - Coverage Determinations, § 20.10.1 - Cardiac Rehabilitation Programs for Chronic Heart Failure; §20.31 - Intensive Cardiac Rehabilitation (ICR) Programs; §20.31.1 - Pritikin Program; §20.31.2 - Ornish Program for Reversing Heart Disease; §20.31.3 – Benson-Henry Institute Cardiac Wellness Program; 13. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §60.1.B- Direct Personal Supervision; §232 - Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished on or After January 1, 2010; 14. Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §140- Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs; §140.2- Cardiac Rehabilitation Program Services Furnished on or after January 1, 2010; §140.3- Intensive Cardiac Rehabilitation Program Services Furnished on or after January 1, 2010; 15. Palmetto LCD L34412- Cardiac Rehabilitation, Effective 10/01/2015; Retired 4/5/2019; 16. Noridian LCA A54068- Outpatient Cardiac Rehabilitation, Effective 10/01/2015; Revised 01/01/2022; 17. Noridian LCA A54070- Outpatient Cardiac Rehabilitation, Effective 10/01/2015; Revised 01/01/2022; 18. Palmetto LCA A53775- Billing and Coding: Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation, Effective 10/01/2015; Revised 8/27/2020	Complex	3/7/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Cardiac rehabilitation (CR) is a physician-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Medical Documentation will be reviewed to determine if cardiac rehabilitation is medically reasonable and necessary as well as meets Federal guidelines and Medicare coverage criteria.	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirementss	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1848(b)(5)- Treatment of Intensive Cardiac Rehabilitation Program; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(2)(CC), (DD)- Medical and Other Services- Cardiac Rehabilitation Program, Intensive Cardiac Rehabilitation Program; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(eee)(1), (4)(A)- Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §410.49 – Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1 –3.6.6; 12. Medicare National Coverage Determinations (NCD), Part 1 - Coverage Determinations, § 20.10.1 - Cardiac Rehabilitation Programs for Chronic Heart Failure; §20.31 - Intensive Cardiac Rehabilitation (ICR) Programs; §20.31.1 - Pritikin Program; §20.31.2 - Ornish Program for Reversing Heart Disease; §20.31.3 – Benson-Henry Institute Cardiac Wellness Program; 13. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §60.1.B- Direct Personal Supervision; §232 - Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished on or After January 1, 2010; 14. Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §140- Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs; §140.2- Cardiac Rehabilitation Program Services Furnished on or after January 1, 2010; §140.3- Intensive Cardiac Rehabilitation Program Services Furnished on or after January 1, 2010; 15. Palmetto LCD L34412- Cardiac Rehabilitation, Effective 10/01/2015; Retired 4/5/2019; 16. Noridian LCA A54068- Outpatient Cardiac Rehabilitation, Effective 10/01/2015; Revised 01/01/2022; 17. Noridian LCA A54070- Outpatient Cardiac Rehabilitation, Effective 10/01/2015; Revised 01/01/2022; 18. Palmetto LCA A53775- Billing and Coding: Frequency and Duration for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation, Effective 10/01/2015; Revised 8/27/2020	Complex	3/7/2019	Approved
Radiographs of the chest are common tests performed in many outpatient offices (radiology and many others), clinics, outpatient hospital departments, inpatient hospital episodes, skilled nursing facilities, homes, and other settings. They can be used for many pulmonary diseases, cardiac diseases, infections and inflammatory diseases, chest and upper abdominal trauma situations, malignant and metastatic diseases, allergic and drug related diseases. This review will ensure chest x-rays are paid when billed appropriately and only when medically necessary. Claims that are billed inappropriately or that do not meet medical necessity requirements will result in an overpayment.	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §411.15(a)(1) – Particular services excluded from coverage, (a) Routine physical checkups (1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening; 6. 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 7. 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §§80.4-80.4.4- Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnosis Code Requirements; 12. Noridian Local Coverage Determination: L37547- Chest X-Ray Policy; Effective 6/22/2018; Revised 11/01/2019; 13. Noridian Local Coverage Article (LCA): A57497- Chest X-Ray Policy, Effective 11/01/2019, Revised 10/01/2020; 14. Current Procedural Terminology 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
Radiographs of the chest are common tests performed in many outpatient offices (radiology and many others), clinics, outpatient hospital departments, inpatient hospital episodes, skilled nursing facilities, homes, and other settings. They can be used for many pulmonary diseases, cardiac diseases, infections and inflammatory diseases, chest and upper abdominal trauma situations, malignant and metastatic diseases, allergic and drug related diseases. This review will ensure chest x-rays are paid when billed appropriately and only when medically necessary. Claims that are billed inappropriately or that do not meet medical necessity requirements will result in an overpayment.	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 §411.15(a)(1) – Particular services excluded from coverage, (a) Routine physical checkups (1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening; 6. 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 7. 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §§80.4-80.4.4- Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician; 9. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnosis Code Requirements; 12. Noridian Local Coverage Determination: L37547- Chest X-Ray Policy; Effective 6/22/2018; Revised 11/01/2019; 13. Noridian Local Coverage Article (LCA): A57497- Chest X-Ray Policy, Effective 11/01/2019, Revised 10/01/2020; 14. Current Procedural Terminology Manual	Complex	4/15/2019	Approved
Physical therapy, speech-language pathology services, and occupational therapy are bundled into the SNF's global per diem payment for a resident's covered Part A stay. They are also subject to the SNF "Part B" consolidated billing requirement for services furnished to SNF Part B residents.	0138 - Skilled Nursing Facility Consolidated Billing for Therapies: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Physical Therapist; Occupational Therapist; Speech-language Pathologist	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §10.3- Types of Services Subject to the Consolidated Billing Requirement for SNF, §20.5- Therapy Services; 7. Medicare Claims Processing Manual, Chapter 7- SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule), §110- Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay; 8. Medicare SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling; 9. HCPCS and CPT Codebook	Automated	2/20/2019	Approved
Physical therapy, speech-language pathology services, and occupational therapy are bundled into the SNF's global per diem payment for a resident's covered Part A stay. They are also subject to the SNF "Part B" consolidated billing requirement for services furnished to SNF Part B residents.	0138 - Skilled Nursing Facility Consolidated Billing for Therapies: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Physical Therapist; Occupational Therapist; Speech-language Pathologist	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §10.3- Types of Services Subject to the Consolidated Billing Requirement for SNF, §20.5- Therapy Services; 7. Medicare Claims Processing Manual, Chapter 7- SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule), §110- Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay; 8. Medicare SNF Consolidated Billing- https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling; 9. HCPCS and CPT Codebook	Automated	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. Services that were not medically reasonable and necessary will be denied and will result in an overpayment.	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules for Particular Items and Services; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1842(p)(4)- Provisions Relating to the Administration of Part B; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A), (a)(10)- Exclusions from Coverage and Medicare as a Secondary Payer; 6. 42 CFR §405.929- Post-Payment Review; 7. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 8. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 9. 42 CFR §405.986- Good Cause for Reopening; 10. CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §10- General Exclusions from Coverage ; 11. CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §§3.1-3.6.6; 13. First Coast Service Options (FCSO) Local Coverage Determination (LCD) L34976, Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) Effective 10/01/2015; Revised 07/11/2021; 14. Novitas LCD L35130 Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 10/01/2015; Revised 07/11/2021; 15. Novitas LCA57752 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 11/21/2019; Revised 07/12/2020; 16. Palmetto LCD L33473 Vertebroplasty/Kyphoplasty, Effective 10/01/2015; Revised 10/24/2019; Retired 11/27/2021; 17. WPS LCD L34592 Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation, Effective 10/01/2015; Retired 12/15/2019; 18. WPS LCD L38213 Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 12/16/2019; Revised 07/01/2021; 19. WPS LCA A57630 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 12/16/2019, Revision 10/01/2020; 20. NGS LCD L33569Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF), Effective 10/01/2015; Revised 12/01/2020; 21. NGS LCA A56178 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF), Effective 12/01/2019; Revised 12/01/2020; 22. Noridian LCD L34106	Complex	2/20/2019	Approved
Vertebroplasty and kyphoplasty will be reviewed for medical necessity whether billed as an initial procedure, a repeat procedure (beyond once in a lifetime) or if performed at more than one vertebral level. Services that were not medically reasonable and necessary will be denied and will result in an overpayment.	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules for Particular Items and Services; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1842(p)(4)- Provisions Relating to the Administration of Part B; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s) - Medical and Other Health Services; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A), (a)(10)- Exclusions from Coverage and Medicare as a Secondary Payer; 6. 42 CFR §405.929- Post-Payment Review; 7. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 8. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 9. 42 CFR §405.986- Good Cause for Reopening; 10. CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §10- General Exclusions from Coverage ; 11. CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 16- General Exclusions From Coverage, §20- Services Not Reasonable and Necessary; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §§3.1-3.6.6; 13. First Coast Service Options (FCSO) Local Coverage Determination (LCD) L34976, Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) Effective 10/01/2015; Revised 07/11/2021; 14. Novitas LCD L35130 Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 10/01/2015; Revised 07/11/2021; 15. Novitas LCA57752 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 11/21/2019; Revised 07/12/2020; 16. Palmetto LCD L33473 Vertebroplasty/Kyphoplasty, Effective 10/01/2015; Revised 10/24/2019; Retired 11/27/2021; 17. WPS LCD L34592 Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation, Effective 10/01/2015; Retired 12/15/2019; 18. WPS LCD L38213 Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 12/16/2019; Revised 07/01/2021; 19. WPS LCA A57630 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF), Effective 12/16/2019, Revision 10/01/2020; 20. NGS LCD L33569Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF), Effective 10/01/2015; Revised 12/01/2020; 21. NGS LCA A56178 Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF), Effective 12/01/2019; Revised 12/01/2020; 22. Noridian LCD L34106	Complex	2/20/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Pulmonary rehabilitation is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical Documentation will be reviewed to determine if pulmonary rehabilitation is medically reasonable and necessary as well as meeting federal guidelines and Medicare coverage criteria.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	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) - Medical and Other Health Services- (fff) Pulmonary Rehabilitation Program; 4. 42 Code of Federal Regulations § 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 7. 42 CFR §405.929- Post-Payment Review; 8. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 9. Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 240.8 - Pulmonary Rehabilitation Services; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1 –3.6.6; 11. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §231- Pulmonary Rehabilitation (PR) Program Services Furnished on or After January 1, 2010; 12. Medicare Claim Processing Manual, Chapter 32- Billing Requirements for Special Services, §140.4- Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010; 13. Noridian LCA A52770 Billing and Coding: Pulmonary Rehabilitation Services; Effective 10/01/2015; Revision Effective Date 03/06/2022; 14. Noridian LCA A56152 Billing and Coding: Pulmonary Rehabilitation Services; Effective 10/08/2018; Revision Effective Date 03/06/2022; 51. AMA CPT Code Book/ HCPCS Level II Codebook	Complex	3/27/2019	Approved
Pulmonary rehabilitation is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical Documentation will be reviewed to determine if pulmonary rehabilitation is medically reasonable and necessary as well as meeting federal guidelines and Medicare coverage criteria.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Hospital Outpatient and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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) - Medical and Other Health Services- (fff) Pulmonary Rehabilitation Program; 4. 42 Code of Federal Regulations § 410.47- Pulmonary Rehabilitation Program: Conditions for Coverage; 5. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 7. 42 CFR §405.929- Post-Payment Review; 8. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 9. Medicare National Coverage Determination Manual, Chapter 1, Part 4, Section 240.8 - Pulmonary Rehabilitation Services; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1 –3.6.6; 11. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §231- Pulmonary Rehabilitation (PR) Program Services Furnished on or After January 1, 2010; 12. Medicare Claim Processing Manual, Chapter 32- Billing Requirements for Special Services, §140.4- Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010; 13. Noridian LCA A52770 Billing and Coding: Pulmonary Rehabilitation Services; Effective 10/01/2015; Revision Effective Date 03/06/2022; 14. Noridian LCA A56152 Billing and Coding: Pulmonary Rehabilitation Services; Effective 10/08/2018; Revision Effective Date 03/06/2022; 51. AMA CPT Code Book/ HCPCS Level II Codebook	Complex	3/27/2019	Approved
Services provided by a freestanding non-hospital ASC (Ambulatory Surgery Center) are included under the SNF Consolidated Billing Provisions. Certain services are not payable because they are included in SNF Consolidated Billing. Codes found in the SNF Consolidated Billing – Part A MAC Updates are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC), Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 20.1.2- Other Excluded Services Beyond the Scope of a SNF Part A Benefit https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 9. Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 110.2.7- Edit to Prevent Payment of Facility Fees for Services Billed by an Ambulatory Surgical Center (ASC) when Rendered to a Beneficiary in a Part A Stay https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 10. SNF Consolidated Billing – Annual Updates for Part A MAC https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling; 11. SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility https://www.cms.gov/files/document/general-explanation-major-categories-snf-cb.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 are overpayments and will be recovered.	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC), Skilled Nursing Facility (SNF)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 20.1.2- Other Excluded Services Beyond the Scope of a SNF Part A Benefit https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 9. Medicare Claims Processing Manual, Chapter 6- Inpatient Part A Billing and SNF Consolidated Billing, § 110.2.7- Edit to Prevent Payment of Facility Fees for Services Billed by an Ambulatory Surgical Center (ASC) when Rendered to a Beneficiary in a Part A Stay https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf; 10. SNF Consolidated Billing – Annual Updates for Part A MAC https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling; 11. SNF Consolidated Billing – General Explanation of the Major Categories for Skilled Nursing Facility https://www.cms.gov/files/document/general-explanation-major-categories-snf-cb.pdf	Automated	4/2/2019	Approved
Claims for ERFA and EVLT for Lower Extremity Varicose Veins not deemed to be medically necessary will be denied based on the guidelines outlined in the respective MAC Jurisdiction LCD(s). Services that are not medically reasonable and necessary will be denied.	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity and Documentation Requirements	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner), and Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 09/30/2021; 9. First Coast LCD L33762- Treatment of Varicose Veins of the Lower Extremity; Effective 10/1/2015; Retired 12/26/2020; 10. First Coast LCD L38720- Treatment of Chronic Venous Insufficiency of the Lower Extremities; Effective 12/27/2020; 11. NGS LCD L33575- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 11/21/2019; 12. Noridian LCD L34209- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 12/01/2019; 13. Noridian LCD L34010- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 12/01/2019; 14. Novitas LCD L34924- Treatment of Chronic Venous Insufficiency of the Lower Extremities; Effective 10/1/2015, Revised 12/27/2020; 15. Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 4/22/2019; Retired 3/10/2020; 16. Palmetto LCD L39121 – Treatment of Varicose Veins of the Lower Extremities; Effective 04/03/2022; 17. WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 09/30/2021; 18. CGS LCA A57305- Billing and Coding: Varicose Veins of the Lower Extremity, Treatment of; Effective 9/26/2019; Revised 09/30/2021; 19. First Coast LCA A55963- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 4/17/2018; Retired 10/15/2021; 20. First Coast LCA A56064- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 7/10/2018; Retired 10/15/2021; 21. First Coast LCA A57781- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 10/03/2018; Retired 12/26/2020; 22. First Coast LCA A58250- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 12/27/2020; Revised 3/11/2021; 23. NGS LCA A52870- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 10/01/2015; Revised 11/21/2019; 24. Noridian LCA A57706- Billing and Coding: Treatment of Varicose Veins of the Lower Extremities; Effective 12/01/2019; 25. Noridian LCA A57707- Billing and Coding: Treatment of Varicose Veins of the Lower	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 not deemed to be medically necessary will be denied based on the guidelines outlined in the respective MAC Jurisdiction LCD(s). Services that are not medically reasonable and necessary will be denied.	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity and Documentation Requirements	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner), and Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1-3.6.6; 8. CGS LCD L34082- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 09/30/2021; 9. First Coast LCD L33762- Treatment of Varicose Veins of the Lower Extremity; Effective 10/1/2015; Retired 12/26/2020; 10. First Coast LCD L38720- Treatment of Chronic Venous Insufficiency of the Lower Extremities; Effective 12/27/2020; 11. NGS LCD L33575- Varicose Veins of the Lower Extremity, Treatment of; Effective 10/1/2015; Revised 11/21/2019; 12. Noridian LCD L34209- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 12/01/2019; 13. Noridian LCD L34010- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 12/01/2019; 14. Novitas LCD L34924- Treatment of Chronic Venous Insufficiency of the Lower Extremities; Effective 10/1/2015, Revised 12/27/2020; 15. Palmetto LCD L33454- Varicose Veins of the Lower Extremities; Effective 10/1/2015, Revised 4/22/2019; Retired 3/10/2020; 16. Palmetto LCD L39121 – Treatment of Varicose Veins of the Lower Extremities; Effective 04/03/2022; 17. WPS LCD L34536- Treatment of Varicose Veins of the Lower Extremities; Effective 10/1/2015; Revised 09/30/2021; 18. CGS LCA A57305- Billing and Coding: Varicose Veins of the Lower Extremity, Treatment of; Effective 9/26/2019; Revised 09/30/2021; 19. First Coast LCA A55963- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 4/17/2018; Retired 10/15/2021; 20. First Coast LCA A56064- Treatment of Varicose Veins of the Lower Extremity- revision to the Part A/B LCD; Effective 7/10/2018; Retired 10/15/2021; 21. First Coast LCA A57781- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 10/03/2018; Retired 12/26/2020; 22. First Coast LCA A58250- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 12/27/2020; Revised 3/11/2021; 23. NGS LCA A52870- Billing and Coding: Treatment of Varicose Veins of the Lower Extremity; Effective 10/01/2015; Revised 11/21/2019; 24. Noridian LCA A57706- Billing and Coding: Treatment of Varicose Veins of the Lower Extremities; Effective 12/01/2019; 25. Noridian LCA A57707- Billing and Coding: Treatment of Varicose Veins of the Lower	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. The less extensive CT scan code(s) will be recovered as an overpayment.	0146 - Computed Tomography Scans: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 – 3.6.6; 7. Medicare Claims Processing Manual, Chapter 12 -Physicians/Non-physician Practitioners, Section 30-Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures; 8. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9. CPT Manual year 2018 to current	Automated	3/27/2019	Approved
When a more extensive CT Scan is performed on the same site as a less extensive CT Scan, the less extensive CT Scan is bundled into the more extensive CT Scan. The less extensive CT scan code(s) will be recovered as an overpayment.	0146 - Computed Tomography Scans: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5. 42 CFR §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 – 3.6.6; 7. Medicare Claims Processing Manual, Chapter 12 -Physicians/Non-physician Practitioners, Section 30-Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures; 8. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction; 9. CPT Manual year 2018 to current	Automated	3/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When a more extensive Magnetic Resonance Imaging is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI. The less extensive MRI procedure code(s) will be recovered as an overpayment(s).	0147 - Magnetic Resonance Imaging Procedures: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2 .Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations §405.929 – Post-payment review; 6. 42 Code of Federal Regulations §405.930 – Failure to respond to additional documentation request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 – 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12 -Physicians/Non-physician Practitioners, Sections 30 – Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures; 9. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.1 – Correct Coding Modifier Indicators (CCMI) and HCPCS Code Modifiers; 10. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction and Section L – More Extensive Procedure for applicable year; 11. CPT Manual year 2015 to current	Automated	3/29/2019	Approved
When a more extensive Magnetic Resonance Imaging is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI. The less extensive MRI procedure code(s) will be recovered as an overpayment(s).	0147 - Magnetic Resonance Imaging Procedures: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2 .Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 Code of Federal Regulations §405.986- Good Cause for Reopening; 5. 42 Code of Federal Regulations §405.929 – Post-payment review; 6. 42 Code of Federal Regulations §405.930 – Failure to respond to additional documentation request; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 – 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12 -Physicians/Non-physician Practitioners, Sections 30 – Correct Coding Policy, (H)- Most Extensive Procedures and (J)- With/Without Procedures; 9. Medicare Claims Processing Manual; Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.1 – Correct Coding Modifier Indicators (CCMI) and HCPCS Code Modifiers; 10. NCCI Policy Manual for Medicare Services, Chapter 1- General Correct Coding Policies, Section A- Introduction and Section L – More Extensive Procedure for applicable year; 11. CPT Manual year 2015 to current	Automated	3/29/2019	Approved
Per Medicare Claims Processing Manual Chapter 12, Section 30.6.9.2 (C), CMS does not reimburse both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. CPT codes 99231 – 99233 will be considered overpayments and will be recovered.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2 .Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980 – Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual, Chapter 12-Physicians/ Nonphysician Practitioners, §30.6.9.2(C)- Subsequent Hospital Visit and Discharge Management on Same Day; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/ Nonphysician Practitioners, §30.6.5- Physicians in Group Practice	Automated	4/22/2019	Approved
Per Medicare Claims Processing Manual Chapter 12, Section 30.6.9.2 (C), CMS does not reimburse both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. CPT codes 99231 – 99233 will be considered overpayments and will be recovered.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2 .Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980 – Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.3- Automated Review; 7. Medicare Claims Processing Manual, Chapter 12-Physicians/ Nonphysician Practitioners, §30.6.9.2(C)- Subsequent Hospital Visit and Discharge Management on Same Day; 8. Medicare Claims Processing Manual, Chapter 12- Physicians/ Nonphysician Practitioners, §30.6.5- Physicians in Group Practice	Automated	4/22/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Mohs Micrographic Surgery is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. This review will verify that the physician who performs the Mohs surgery is acting as both surgeon and pathologist. Codes 17311 and 17313 are used for the first layer (stage) only and include the work of excision and pathology of up to five tissue blocks. These codes are not targeted as it is assumed all patients will have first stage but these codes may be used to validate that the physician is acting as both surgeon and pathologist. Reviewers will determine if the correct number of units have been billed for additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314. Billing of excessive or insufficient units or a change in coding could result in an over- or underpayment and will be adjusted accordingly.	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3 Verifying Potential Errors and Taking Corrective Actions; §§3.1-3.6.6; 8. AHA Coding Clinic for HCPCS, Third Quarter 2013, Volume 13, Number 3, Page 1 Reporting MOHS micrographic surgery (MMS); 9. CPT Assistant, October 2014, Volume 24, Issue 10, Page 14 Frequently Asked Questions, Mohs Surgery, Tissue Block; 10. CPT Assistant, November 2006, Volume 16, Issue 11, Pages 1-7 Mohs Micrographic Surgery; 11. CPT Assistant, February 2014, Volume 24, Issue 2, Page 10 Coding Clarification: Mohs Surgery; 12. AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Complex	4/30/2019	Approved
Mohs Micrographic Surgery is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. This review will verify that the physician who performs the Mohs surgery is acting as both surgeon and pathologist. Codes 17311 and 17313 are used for the first layer (stage) only and include the work of excision and pathology of up to five tissue blocks. These codes are not targeted as it is assumed all patients will have first stage but these codes may be used to validate that the physician is acting as both surgeon and pathologist. Reviewers will determine if the correct number of units have been billed for additional Mohs micrographic technique staging unit(s) for HCPCS 17312 and 17314. Billing of excessive or insufficient units or a change in coding could result in an over- or underpayment and will be adjusted accordingly.	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3 Verifying Potential Errors and Taking Corrective Actions; §§3.1-3.6.6; 8. AHA Coding Clinic for HCPCS, Third Quarter 2013, Volume 13, Number 3, Page 1 Reporting MOHS micrographic surgery (MMS); 9. CPT Assistant, October 2014, Volume 24, Issue 10, Page 14 Frequently Asked Questions, Mohs Surgery, Tissue Block; 10. CPT Assistant, November 2006, Volume 16, Issue 11, Pages 1-7 Mohs Micrographic Surgery; 11. CPT Assistant, February 2014, Volume 24, Issue 2, Page 10 Coding Clarification: Mohs Surgery; 12. AMA CPT Manual, Evaluation and Management Services Guidelines (1999 through present)	Complex	4/30/2019	Approved
The Medicare Physician Fee Schedule (MPFS) is the primary method of payment for enrolled health care professionals. Documentation will be reviewed to determine if professional services that affecting MPFS payment meet Medicare coverage criteria and applicable coding guidelines.	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §414- Payment for Part B Medical and other Health Services, Subpart A – General Provisions, Subpart B – Physicians and other Practitioners, Subpart E – Determination of Reasonable Charges under ESRD Program; 7. 42 CFR §414.40- Coding and Ancillary Policies; 9. 42 CFR §415- Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings; 10. 42 CFR §419.44- Payment Reductions for Procedures; 11. Medicare Claims Processing Manual, Chapter 12- Physicians/Non-physician Practitioners; 12. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements; 13. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 14. American Medical Association (AMA), Current Procedural Terminology (CPT); 15. American Medical Association, Healthcare Common Procedure Coding System Level II; 16. American Medical Association Current Procedural Terminology Assistant; 17. National Correct Coding Initiatives (NCCI) Policy Manual; 18. 1995 & 1997 Documentation Guidelines for Evaluation & Management Services; 19. CMS Physician Fee Schedule, Relative Value Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html; 20. American Hospital Association (AMA) Coding Clinic	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 MPFS payment meet Medicare coverage criteria and applicable coding guidelines.	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §414- Payment for Part B Medical and other Health Services, Subpart A – General Provisions, Subpart B – Physicians and other Practitioners, Subpart E – Determination of Reasonable Charges under ESRD Program; 7. 42 CFR §414.40- Coding and Ancillary Policies; 9. 42 CFR §415- Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings; 10. 42 CFR §419.44- Payment Reductions for Procedures; 11. Medicare Claims Processing Manual, Chapter 12- Physicians/Non-physician Practitioners; 12. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements; 13. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 14. American Medical Association (AMA), Current Procedural Terminology (CPT); 15. American Medical Association, Healthcare Common Procedure Coding System Level II; 16. American Medical Association Current Procedural Terminology Assistant; 17. National Correct Coding Initiatives (NCCI) Policy Manual; 18. 1995 & 1997 Documentation Guidelines for Evaluation & Management Services; 19. CMS Physician Fee Schedule, Relative Value Files, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html; 20. American Hospital Association (AMA) Coding Clinic	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. Coding that is not supported by the information in the medical record may result in over or under payment.	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR § 414.40 - Coding and Ancillary Policies; 6. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §3.6.2.4- Coding Determinations; 9. Medicare Claims Processing Manual, Chapter 12- Physician/ Non-physician Practitioners § 40.1- Definition of a Global Surgical Package; 10. 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; 11. Ambulatory Surgical Center Payment System; Addendum AA; Payment indicators A2 (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight), G2 (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight); J8 (Device-intensive procedure; paid at adjusted rate. ASC Payment rates, P2 (Office-based surgical procedure on ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight), and R2 (Office-based surgical procedure on ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight) available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html; 12. National Correct Coding Initiative (NCCI) Policy Manual; 13. First Coast Service Operations, LCA A55895 – Ambulatory Surgical Center (ASC) Inappropriate Use of Modifier 50, Effective 03/26/18; 14. American Medical Association (AMA), Current Procedure Terminology; 15. American Medical Association Current Procedural Terminology Assistant; 16. American Hospital Association Coding Clinic for Health Common Procedure Coding System	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. Coding that is not supported by the information in the medical record may result in over or under payment.	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (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 § 414.40 - Coding and Ancillary Policies; 6. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions §3.6.2.4- Coding Determinations; 9. Medicare Claims Processing Manual, Chapter 12- Physician/ Non-physician Practitioners § 40.1- Definition of a Global Surgical Package; 10. 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; 11. Ambulatory Surgical Center Payment System; Addendum AA; Payment indicators A2 (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight), G2 (Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight); J8 (Device-intensive procedure; paid at adjusted rate. ASC Payment rates, P2 (Office-based surgical procedure on ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight), and R2 (Office-based surgical procedure on ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight) available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html; 12. National Correct Coding Initiative (NCCI) Policy Manual; 13. First Coast Service Operations, LCA A55895 – Ambulatory Surgical Center (ASC) Inappropriate Use of Modifier 50, Effective 03/26/18; 14. American Medical Association (AMA), Current Procedure Terminology; 15. American Medical Association Current Procedural Terminology Assistant; 16. American Hospital Association Coding Clinic for Health Common Procedure Coding System	Complex	5/28/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0154 - Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Medical and Other Health Services; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)- (16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9. 42 CFR 410.40- Coverage of ambulance services, (a) Definitions (b) Basic rules, (c) Levels of service, (d)(1), (d)(2), (d)(3) Paramedic ALS intercept services, and (e)(1)(2) and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis; 10. 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements; 11. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary; 12. 42 CFR 424.36- Signature Requirements; 13. 42 CFR 414.605 Definitions; 14. 42 CFR 414.610 Basis of Payment; 15. 42 CFR 424.37 Evidence of Authority to Sign on behalf of the Beneficiary; 16. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation; 17. Medicare Program Integrity Manual; Chapter 3 - Verifying Potential Errors and Taking Corrective Actions; §3.3.2.4 - Signature Requirements; 18. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 19. Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.2 – Summary of the Benefit, §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Code; 20. Medicare Claims Processing Manual, Chapter 30 – Financial Liability Protections, §50.15.2 – Emergencies or Urgent Situations/Ambulance Transport; 21. Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22. Novitas, LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/15, Revised 10/01/20; 23. FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services, Effective Date 6/28/2018, Revised 11/28/19; 24. FCSO, LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 25. FCSO LCA A57674,	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 non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0154 - Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Medical and Other Health Services; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)- (16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 9. 42 CFR 410.40- Coverage of ambulance services, (a) Definitions (b) Basic rules, (c) Levels of service, (d)(1), (d)(2), (d)(3) Paramedic ALS intercept services, and (e)(1)(2) and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis; 10. 42 CFR 410.41- Requirements for ambulance suppliers, (c) Billing and reporting requirements; 11. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services not Reasonable and Necessary; 12. 42 CFR 424.36- Signature Requirements; 13. 42 CFR 414.605 Definitions; 14. 42 CFR 414.610 Basis of Payment; 15. 42 CFR 424.37 Evidence of Authority to Sign on behalf of the Beneficiary; 16. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation; 17. Medicare Program Integrity Manual; Chapter 3 - Verifying Potential Errors and Taking Corrective Actions; §3.3.2.4 - Signature Requirements; 18. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 19. Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.2 – Summary of the Benefit, §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Code; 20. Medicare Claims Processing Manual, Chapter 30 – Financial Liability Protections, §50.15.2 – Emergencies or Urgent Situations/Ambulance Transport; 21. Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22. Novitas, LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/15, Revised 10/01/20; 23. FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services, Effective Date 6/28/2018, Revised 11/28/19; 24. FCSO, LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 25. FCSO LCA A57674,	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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §414.40 Coding and Ancillary Policies; 8. 42 CFR §419.44 Payment Reductions for Procedures; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. 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; 11. Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40.4- Payment for Terminated Procedures; 12. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 13. American Medical Association (AMA), Current Procedural Terminology, Appendix A Modifiers; 14. American Hospital Association (AHA) Coding Clinic for Healthcare Common Procedural Coding System 2007, Volume 7, Number 1, Page 1- Use of Modifiers 52, 73, and 74 and Anesthesia Reporting under OPPS; 15.American Hospital Association (AHA) Coding Clinic for Healthcare Common Procedural Coding System 2008, Volume 8, Number 2, Pages 1-4- Special Issue: Modifiers 52, 73, and 74; 16. American Hospital Association (AHA) Coding Clinic for HCPCS 2016, Volume 16, Number 1, Page 12- Appropriate Use of Modifiers for Discontinued Services under the OPPS; 17. 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 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §414.40 Coding and Ancillary Policies; 8. 42 CFR §419.44 Payment Reductions for Procedures; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. 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; 11. Medicare Claims Processing Manual, Chapter 14- Ambulatory Surgical Centers, §40.4- Payment for Terminated Procedures; 12. Medicare Claims Processing Manual, Chapter 23- Fee Schedule Administration and Coding Requirements, §20.3- Use and Acceptance of HCPCS Codes and Modifiers; 13. American Medical Association (AMA), Current Procedural Terminology, Appendix A Modifiers; 14. American Hospital Association (AHA) Coding Clinic for Healthcare Common Procedural Coding System 2007, Volume 7, Number 1, Page 1- Use of Modifiers 52, 73, and 74 and Anesthesia Reporting under OPPS; 15.American Hospital Association (AHA) Coding Clinic for Healthcare Common Procedural Coding System 2008, Volume 8, Number 2, Pages 1-4- Special Issue: Modifiers 52, 73, and 74; 16. American Hospital Association (AHA) Coding Clinic for HCPCS 2016, Volume 16, Number 1, Page 12- Appropriate Use of Modifiers for Discontinued Services under the OPPS; 17. 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
On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. Therapy services billed separately during a home health episode of care will be recouped as the services are bundled into the Home Health Consolidated billing payment.	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Hospital, Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20- Home Health Prospective Payment System (HH PPS) Consolidated Billing; 7. Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20.2.2 - Therapy Editing	Automated	7/15/2019	Approved
On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. Therapy services billed separately during a home health episode of care will be recouped as the services are bundled into the Home Health Consolidated billing payment.	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Hospital, Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20- Home Health Prospective Payment System (HH PPS) Consolidated Billing; 7. Medicare Claims Processing Manual, Chapter 10- Home Health Agency Billing, §20.2.2 - Therapy Editing	Automated	7/15/2019	Approved
Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter. CPT codes 92133 and/or 92134 will be considered in this edit, if billed together during the same patient encounter, on the same date of service. Only one is allowed per day, therefore the less comprehensive CPT/HCPCS Code - 92134 will be recovered as an overpayment.	0159 - Ophthalmic Diagnostic CPT Codes: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. CGS LCA A56692- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 7/11/2019; Revised 7/29/2021; 9. First Coast Service Options LCA A57804- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 10/03/2018, Revised 8/6/2021; 10. National Government Services (NGS) LCA A56537- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/01/2019; Revised 10/01/2020; 11. Novitas LCA A57600- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging; Effective 10/31/2019, Revised 8/06/2021; 12. Palmetto LCA A56825- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/08/2019; Revised 10/17/2019; 13. Wisconsin Physicians Service Insurance Corporation (WPS) LCA A56916- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/29/2019; Revised 9/30/3021; 14. AMA HCPCS and CPT Codebook	Automated	6/19/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Based on CPT Code descriptions, CPT Code 92133 and/or 92134 cannot be reported at the same patient encounter. CPT codes 92133 and/or 92134 will be considered in this edit, if billed together during the same patient encounter, on the same date of service. Only one is allowed per day, therefore the less comprehensive CPT/HCPCS Code - 92134 will be recovered as an overpayment.	0159 - Ophthalmic Diagnostic CPT Codes: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. CGS LCA A56692- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 7/11/2019; Revised 7/29/2021; 9. First Coast Service Options LCA A57804- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 10/03/2018, Revised 8/6/2021; 10. National Government Services (NGS) LCA A56537- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/01/2019; Revised 10/01/2020; 11. Novitas LCA A57600- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging; Effective 10/31/2019, Revised 8/06/2021; 12. Palmetto LCA A56825- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/08/2019; Revised 10/17/2019; 13. Wisconsin Physicians Service Insurance Corporation (WPS) LCA A56916- Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI); Effective 8/29/2019; Revised 9/30/3021; 14. AMA HCPCS and CPT Codebook	Automated	6/19/2019	Approved
Medical documentation will be reviewed to determine if the use of intravenous immune globulin for the treatment of Autoimmune Blistering Diseases (AMBDs) meets Medicare coverage criteria and is reasonable and necessary. Services that are not medically necessary will result in an overpayment.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Freestanding Clinic; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare National Coverage Determinations (NCD) Manual, Part 4- Coverage Determinations, Section 250.3- Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases. Effective upon Implementation of ICD-10; 6. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, Section 13.5.4 Reasonable and Necessary Provisions in LCDs; 7. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, Section 80.6- Intravenous Immune Globulin; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. CGS Administrators LCD L35891- Intravenous Immune Globulin; Effective 10/01/2015; Revised 04/01/2021; 10. CGS and Noridian LCD L33610 – Intravenous Immune Globulin; Effective 10/01/15; Revised 04/01/21; 11. First Coast Service Options (FCSO) LCD L34007- Intravenous Immune Globulin; Effective 10/01/2015; Revised 11/28/2019; 12. Noridian Healthcare Solutions LCD L34314- Immune Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 02/01/2020; 13. Noridian Healthcare Solutions LCD L34074- Immune Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 02/01/2020; 14. Novitas LCD L35093- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 11/14/2019; 15. Palmetto GBA L34580- Intravenous Immunoglobulin (IVIG); Effective 10/01/2015; Revised 10/04/2020; 16. WPS LCD L34771- Immune Globulins; Effective 10/01/2015; Revised 10/01/2020; 17. NGS LCA A52446- Intravenous Immune Globulin IVIG; Effective 10/01/2015; Revised 08/01/21; 18. CGS LCA A56779- Billing and Coding: Intravenous Immune Globulin; Effective 08/01/2019; Revised 04/01/2021; 19. FCSO LCA A57778- Billing and Coding: Intravenous Immune Globulin; Effective 10/03/2018: Revised 10/01/2020; 20. Noridian LCA A57187- Billing and Coding: Immune Globulin Intravenous (IVIg); Effective 10/01/2019; Revised 10/01/21; 21. Noridian LCA A54643- Intravenous Immune Globulin: (IVIg) – NCD – 250.3; Effective 11/07/2015; Revised 11/07/2015; 22. Noridian LCA A57194- Billing and Coding: Immune Globulin Intravenous (IVIg); Effective 10/01/2019; Revised 10/01/21; 23. Novitas LCA A56786- Billing and Coding: Intravenous Immune Globulin (IVIG); Effective 08/08/2019; Revised 10/01/2020; 24. Palmetto LCA A56718- Billing and Coding: Intravenous Immune Globulin (IVIG); Effective 07/25/2019; Revised 10/01/21; 25. WPS LCA	Complex	8/20/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medical documentation will be reviewed to determine if the use of intravenous immune globulin for the treatment of Autoimmune Blistering Diseases (AMBDs) meets Medicare coverage criteria and is reasonable and necessary. Services that are not medically necessary will result in an overpayment.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Freestanding Clinic; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare National Coverage Determinations (NCD) Manual, Part 4- Coverage Determinations, Section 250.3- Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases. Effective upon Implementation of ICD-10; 6. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, Section 13.5.4 Reasonable and Necessary Provisions in LCDs; 7. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, Section 80.6- Intravenous Immune Globulin; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. CGS Administrators LCD L35891- Intravenous Immune Globulin; Effective 10/01/2015; Revised 04/01/2021; 10. CGS and Noridian LCD L33610 – Intravenous Immune Globulin; Effective 10/01/15; Revised 04/01/21; 11. First Coast Service Options (FCSO) LCD L34007- Intravenous Immune Globulin; Effective 10/01/2015; Revised 11/28/2019; 12. Noridian Healthcare Solutions LCD L34314- Immune Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 02/01/2020; 13. Noridian Healthcare Solutions LCD L34074- Immune Globulin Intravenous (IVIg); Effective 10/01/2015; Revised 02/01/2020; 14. Novitas LCD L35093- Intravenous Immune Globulin (IVIG); Effective 10/01/2015; Revised 11/14/2019; 15. Palmetto GBA L34580- Intravenous Immunoglobulin (IVIG); Effective 10/01/2015; Revised 10/04/2020; 16. WPS LCD L34771- Immune Globulins; Effective 10/01/2015; Revised 10/01/2020; 17. NGS LCA A52446- Intravenous Immune Globulin IVIG; Effective 10/01/2015; Revised 08/01/21; 18. CGS LCA A56779- Billing and Coding: Intravenous Immune Globulin; Effective 08/01/2019; Revised 04/01/2021; 19. FCSO LCA A57778- Billing and Coding: Intravenous Immune Globulin; Effective 10/03/2018: Revised 10/01/2020; 20. Noridian LCA A57187- Billing and Coding: Immune Globulin Intravenous (IVIg); Effective 10/01/2019; Revised 10/01/21; 21. Noridian LCA A54643- Intravenous Immune Globulin: (IVIg) – NCD – 250.3; Effective 11/07/2015; Revised 11/07/2015; 22. Noridian LCA A57194- Billing and Coding: Immune Globulin Intravenous (IVIg); Effective 10/01/2019; Revised 10/01/21; 23. Novitas LCA A56786- Billing and Coding: Intravenous Immune Globulin (IVIG); Effective 08/08/2019; Revised 10/01/2020; 24. Palmetto LCA A56718- Billing and Coding: Intravenous Immune Globulin (IVIG); Effective 07/25/2019; Revised 10/01/21; 25. WPS LCA	Complex	8/20/2019	Approved
Documentation will be reviewed to determine if correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §90.2- Drugs, Biologicals, and Radiopharmaceuticals; 10. Annual CPT Manual	Complex	11/18/2019	Approved
Documentation will be reviewed to determine if correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §90.2- Drugs, Biologicals, and Radiopharmaceuticals; 10. Annual CPT Manual	Complex	11/18/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
All diagnostic tests, including Computed Tomography (CT) Coronary Angiography, must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. The physician who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, as part of a routine physical checkup are excluded from coverage.	0162 - Computerized Tomography Coronary Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, §1862(a)(1)(A), Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA 1862(a)(7), Exclusions from Coverage and Medicare as a Secondary Payer; 3. SSA, §1833(e) – Payment of benefits; 4. 42 CFR §411.15(a)(1) – Particular services excluded from coverage; Routine physical checkups; 5. 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 6. 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 8. 42 CFR §405.986- Good Cause for Reopening; 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations 220- Radiology; 220.1- Computed Tomography (CT) §A- General, and §F- Computed Tomographic Angiography (CTA); 10. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnosis Code Requirements; 13. NGS Local Coverage Determination (LCD): Cardiac Computed Tomography (CCT) and CORONARY Computed Tomography Angiography (CCTA) (L33559), Effective 10/01/2015, Revised 10/01/2019; 14. NGS Local Coverage Article (LCA) Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (A56737), Effective 08/01/19; Revised 10/01/19; 15. WPS Local Coverage Determination (LCD): CORONARY Computed Tomography Angiography (CCTA) (L35121), Effective 10/01/2015, Revised 10/28/21; 16. WPS Local Coverage Article (LCA): Billing and Coding: Coronary Computed Tomography Angiography (CCTA) (A57552), Effective 11/28/19, Revised 10/28/21; 17. CGS Local Coverage Determination (LCD): Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (L33947), Effective 10/01/2015, Revised 09/30/2021; 18. CGS Local Coverage Article (LCA): Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (A56451), Effective 10/01/16; Revised 09/30/21; 19. First Coast Local Coverage Determination (LCD): Computed Tomographic Angiography of the Chest, Head and Coronary Arteries (L33282), Effective 10/01/15; Revised 10/01/19; 20. First Coast Local Coverage Article (LCA): Billing and Coding: Computed Tomographic Angiography of the Chest, Heart, and Coronary Arteries (A57061), Effective 10/03/18; 21. Palmetto Local Coverage Determination (LCD) L33423: Cardiac Computed Tomography and Angiography (CCTA), Effective 10/01/15; Revised	Complex	7/22/2019	Approved
All diagnostic tests, including Computed Tomography (CT) Coronary Angiography, must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. The physician who orders the service must maintain documentation of medical necessity in the beneficiary's medical record. Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, as part of a routine physical checkup are excluded from coverage.	0162 - Computerized Tomography Coronary Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, §1862(a)(1)(A), Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA 1862(a)(7), Exclusions from Coverage and Medicare as a Secondary Payer; 3. SSA, §1833(e) – Payment of benefits; 4. 42 CFR §411.15(a)(1) – Particular services excluded from coverage; Routine physical checkups; 5. 42 CFR 486.100 - Condition for coverage: Compliance with Federal, State, and local laws and regulations; 6. 42 CFR, §410.32, Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 7. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 8. 42 CFR §405.986- Good Cause for Reopening; 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations 220- Radiology; 220.1- Computed Tomography (CT) §A- General, and §F- Computed Tomographic Angiography (CTA); 10. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6.1- Definitions; 11. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.4.1.3- Diagnosis Code Requirements; 13. NGS Local Coverage Determination (LCD): Cardiac Computed Tomography (CCT) and CORONARY Computed Tomography Angiography (CCTA) (L33559), Effective 10/01/2015, Revised 10/01/2019; 14. NGS Local Coverage Article (LCA) Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (A56737), Effective 08/01/19; Revised 10/01/19; 15. WPS Local Coverage Determination (LCD): CORONARY Computed Tomography Angiography (CCTA) (L35121), Effective 10/01/2015, Revised 10/28/21; 16. WPS Local Coverage Article (LCA): Billing and Coding: Coronary Computed Tomography Angiography (CCTA) (A57552), Effective 11/28/19, Revised 10/28/21; 17. CGS Local Coverage Determination (LCD): Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (L33947), Effective 10/01/2015, Revised 09/30/2021; 18. CGS Local Coverage Article (LCA): Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (A56451), Effective 10/01/16; Revised 09/30/21; 19. First Coast Local Coverage Determination (LCD): Computed Tomographic Angiography of the Chest, Head and Coronary Arteries (L33282), Effective 10/01/15; Revised 10/01/19; 20. First Coast Local Coverage Article (LCA): Billing and Coding: Computed Tomographic Angiography of the Chest, Heart, and Coronary Arteries (A57061), Effective 10/03/18; 21. Palmetto Local Coverage Determination (LCD) L33423: Cardiac Computed Tomography and Angiography (CCTA), Effective 10/01/15; Revised	Complex	7/22/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Ambulance transports of a hospice patient, which are related to the terminal illness and occur after the effective date of election, are the responsibility of the hospice provider. Payment for the ambulance claim will be recouped if the above condition occurs and separate payment was paid to the provider.	0163 - Ambulance Services Billed During Hospice: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(dd)(1) Hospice Care; Hospice Program; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §405.929- Post-Payment Review; 7. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 8. 42 Code of Federal Regulations (CFR) §418.54(a)- Standard: Initial Assessment; 9. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 11. Medicare Benefit Policy Manual, Chapter 9- Coverage of Hospice Services Under Hospital Insurance, §40.1.9- Other Items and Services; 12. Medicare Claims Processing Manual, Chapter 11- Processing Hospice Claims, §50- Billing and Payment for Services Unrelated to Terminal Illness; 13. American Medical Association HCPCS and CPT Codebook	Automated	7/23/2019	Approved
Ambulance transports of a hospice patient, which are related to the terminal illness and occur after the effective date of election, are the responsibility of the hospice provider. Payment for the ambulance claim will be recouped if the above condition occurs and separate payment was paid to the provider.	0163 - Ambulance Services Billed During Hospice: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(dd)(1) Hospice Care; Hospice Program; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. 42 CFR §405.929- Post-Payment Review; 7. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 8. 42 Code of Federal Regulations (CFR) §418.54(a)- Standard: Initial Assessment; 9. 42 Code of Federal Regulations (CFR) §424.5(a)(6)- Sufficient Information; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 11. Medicare Benefit Policy Manual, Chapter 9- Coverage of Hospice Services Under Hospital Insurance, §40.1.9- Other Items and Services; 12. Medicare Claims Processing Manual, Chapter 11- Processing Hospice Claims, §50- Billing and Payment for Services Unrelated to Terminal Illness; 13. American Medical Association HCPCS and CPT Codebook	Automated	7/23/2019	Approved
A Bilateral Indicator of "3" indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with either a modifier 50 or modifiers RT and LT, and a '2' in the units field, reimbursement is based on 100% of the Medicare allowed amount for each side less any applicable multiple procedure pricing rules. This query identifies claims with underpayments due to code being submitted with a quantity of "2" when performed bilaterally.	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements – Addendum – Medicare Physician Fee Schedule Database (PFSDB) Record Layouts and Field Descriptions https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf; 7. Medicare Claims Processing Manual: Chapter 23, Sec. 50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout – Bilateral Surgery Indicator (Mod 50) 3; 8. Medicare Claims Processing Manual, Chapter 12, §40.7- Claims for Bilateral Surgeries C. 3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf	Automated	9/24/2019	Approved
A Bilateral Indicator of "3" indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with either a modifier 50 or modifiers RT and LT, and a '2' in the units field, reimbursement is based on 100% of the Medicare allowed amount for each side less any applicable multiple procedure pricing rules. This query identifies claims with underpayments due to code being submitted with a quantity of "2" when performed bilaterally.	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements – Addendum – Medicare Physician Fee Schedule Database (PFSDB) Record Layouts and Field Descriptions https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf; 7. Medicare Claims Processing Manual: Chapter 23, Sec. 50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout – Bilateral Surgery Indicator (Mod 50) 3; 8. Medicare Claims Processing Manual, Chapter 12, §40.7- Claims for Bilateral Surgeries C. 3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf	Automated	9/24/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Under specific requirements, Medicare covers FDG (fluorodeoxyglucose) Positron Emission Tomography (PET) scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be reviewed to determine if the utilization of PET scan for the diagnosis or treatment of dementing neurodegenerative diseases is medically necessary according to Medicare coverage indications.	0165 - Positron Emission Tomography for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefit; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §424.5- Basic Conditions, (a)(6)- Sufficient Information; 8. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 9. 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 10. National Coverage Determination Manual, Ch. 1, §220.6.13 FDG Positron Emission Tomography (PET) for Dementia and Neurodegenerative Diseases; 11. Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.1- Billing Instructions, (D)- Post-Payment Review for PET Scans; 13. Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.12- Coverage for PET Scans for Dementia and Neurodegenerative Diseases; 14.Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; 15. Novitas LCA A53134: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions; Effective 10/01/2015; Revised 04/25/2021; 16. Noridian LCA A54666: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 10/29/2021; 17. Noridian LCA A54668: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 10/29/2021	Complex	9/25/2019	Approved
Under specific requirements, Medicare covers FDG (fluorodeoxyglucose) Positron Emission Tomography (PET) scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be reviewed to determine if the utilization of PET scan for the diagnosis or treatment of dementing neurodegenerative diseases is medically necessary according to Medicare coverage indications.	0165 - Positron Emission Tomography for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefit; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §424.5- Basic Conditions, (a)(6)- Sufficient Information; 8. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 9. 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 10. National Coverage Determination Manual, Ch. 1, §220.6.13 FDG Positron Emission Tomography (PET) for Dementia and Neurodegenerative Diseases; 11. Medicare Program Integrity Manual, Ch. 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 12. Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.1- Billing Instructions, (D)- Post-Payment Review for PET Scans; 13. Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.12- Coverage for PET Scans for Dementia and Neurodegenerative Diseases; 14.Medicare Claims Processing Manual, Ch. 13- Radiology Services and Other Diagnostic Procedures, §60.3.1- Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; 15. Novitas LCA A53134: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Non-Oncologic Conditions; Effective 10/01/2015; Revised 04/25/2021; 16. Noridian LCA A54666: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 10/29/2021; 17. Noridian LCA A54668: Positron Emission Tomography Scans Coverage; Effective 10/1/2015; Revised 10/29/2021	Complex	9/25/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for a procedure is submitted and the surgeon's claim for the procedure is also submitted. The documentation for this procedure is the same as is the CPT/ HCPCS code billed. If, after complex review, there is a denial of the procedure code on the facility claim that is upheld, recover the physician claim for that same code automatically. Recouped procedure codes will result in an overpayment.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Catheterizations Billed as Separate Procedures	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. 42 Code of Federal Regulations §411.15(k)(1), Particular services excluded from coverage (k) Any services that are not reasonable and necessary for one of the following purposes: (1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 7. 42 Code of Federal Regulations §424.5(a)(6), Basic conditions (a) As a basis for Medicare payment, the following conditions must be met: (6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.; 8. CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 - General Exclusions from Coverage §20- services not reasonable and necessary; 9. CMS Pub. 100-08, Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, Section 3.2.3- Requesting Additional Documentation During Prepayment and Post payment Review; 10. NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare, Section I. Cardiovascular Services, number 21	Automated	9/27/2019	Approved
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for a procedure is submitted and the surgeon's claim for the procedure is also submitted. The documentation for this procedure is the same as is the CPT/ HCPCS code billed. If, after complex review, there is a denial of the procedure code on the facility claim that is upheld, recover the physician claim for that same code automatically. Recouped procedure codes will result in an overpayment.	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsies and Right Heart Catheterizations Billed as Separate Procedures	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. 42 Code of Federal Regulations §411.15(k)(1), Particular services excluded from coverage (k) Any services that are not reasonable and necessary for one of the following purposes: (1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; 7. 42 Code of Federal Regulations §424.5(a)(6), Basic conditions (a) As a basis for Medicare payment, the following conditions must be met: (6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.; 8. CMS Pub. 100-02 Medicare Benefit Policy Manual, Chapter 16 - General Exclusions from Coverage §20- services not reasonable and necessary; 9. CMS Pub. 100-08, Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, Section 3.2.3- Requesting Additional Documentation During Prepayment and Post payment Review; 10. NCCI Manuals, Chapter 11- Medicine & E/M CPT Codes 90000-99999 for National Correct Coding Initiative Policy Manual for Medicare, Section I. Cardiovascular Services, number 21	Automated	9/27/2019	Approved
All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment. Unbundled services will be denied and result in an overpayment.	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Hospital	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3.B- Outpatient Services Treated as Inpatient Services - Preadmission Diagnostic Services; §40.3(D) Outpatient Services Treated as Inpatient Services - Other Preadmission Services; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6	Automated	11/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment. Unbundled services will be denied and result in an overpayment.	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 7. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §40.3.B- Outpatient Services Treated as Inpatient Services - Preadmission Diagnostic Services; §40.3(D) Outpatient Services Treated as Inpatient Services - Other Preadmission Services; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6	Automated	11/27/2019	Approved
Documentation will be reviewed to determine if diagnostic (aka stand-alone) renal and peripheral angiography procedures meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0170 - Renal and Peripheral Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. National Correct Coding Initiative Policy Manual, Chapter 1 - General Correct Coding Policies, §E- Modifiers and Modifier Indicators; 9. National Correct Coding Initiative Policy Manual, Chapter 5 - Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems; 10. National Correct Coding Initiative Policy Manual, Chapter 9 - Radiology Services; 11. First Coast LCD L36767 - Aortography and Peripheral Angiography; Effective 10/31/2016; Revised 10/01/2019; 12. First Coast LCA A55847 – Aortography and Peripheral Angiography Coding Guidelines; Effective 10/31/16; Retired 10/01/2019; 13. Novitas LCD L35092 - Diagnostic Abdominal Aortography and Renal Angiography Effective 10/01/2015; Revised 11/7/2019; 14. Novitas LCA A56682- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography; Effective date 7/11/2019; Revised 01/19/2022; 15. Annual American Medical Association CPT Manual; Surgery, Cardiovascular; Appendix L Vascular Families	Complex	11/19/2019	Approved
Documentation will be reviewed to determine if diagnostic (aka stand-alone) renal and peripheral angiography procedures meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0170 - Renal and Peripheral Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. National Correct Coding Initiative Policy Manual, Chapter 1 - General Correct Coding Policies, §E- Modifiers and Modifier Indicators; 9. National Correct Coding Initiative Policy Manual, Chapter 5 - Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems; 10. National Correct Coding Initiative Policy Manual, Chapter 9 - Radiology Services; 11. First Coast LCD L36767 - Aortography and Peripheral Angiography; Effective 10/31/2016; Revised 10/01/2019; 12. First Coast LCA A55847 – Aortography and Peripheral Angiography Coding Guidelines; Effective 10/31/16; Retired 10/01/2019; 13. Novitas LCD L35092 - Diagnostic Abdominal Aortography and Renal Angiography Effective 10/01/2015; Revised 11/7/2019; 14. Novitas LCA A56682- Billing and Coding: Diagnostic Abdominal Aortography and Renal Angiography; Effective date 7/11/2019; Revised 01/19/2022; 15. Annual American Medical Association CPT Manual; Surgery, Cardiovascular; Appendix L Vascular Families	Complex	11/19/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria.	0171 - Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §50 Drugs and Biologicals; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals, §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements; §80.9- Required Modifiers for ESAs Administered to Non-ESRD Patients; and §80.12- Claim Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy; 10. National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions; 11. CGS Administrators, LLC, LCD L34356- Erythropoiesis Stimulating Agents (ESA), Effective 10/01/2015; Revised 4/28/2022; 12. WPS LCD L34633- Erythropoiesis Stimulating Agents; Effective 10/01/2015; Revised 7/01/2021; 13 .FCSO LCD L36276- Erythropoiesis Stimulating Agents. Effective 10/01/2015; Revised 9/7/2021; 14. CGS Administrators, LLC, LCA A56462- Billing and Coding: Erythropoiesis Stimulating Agents (ESA), Effective 10/03/2019; Revised 4/7/2022; 15. WPS LCA A56795- Billing and Coding: Erythropoiesis Stimulating Agents; Effective 08/01/2019; Revised 10/01/2021; 16. WPS LCA A57844- Response to Comments: Erythropoiesis Stimulating Agents; Effective 2/9/2020	Complex	12/27/2019	Approved
Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the use of ESA in cancer and related neoplastic conditions meets Medicare coverage criteria.	0171 - Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §50 Drugs and Biologicals; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals, §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements; §80.9- Required Modifiers for ESAs Administered to Non-ESRD Patients; and §80.12- Claim Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy; 10. National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions; 11. CGS Administrators, LLC, LCD L34356- Erythropoiesis Stimulating Agents (ESA), Effective 10/01/2015; Revised 4/28/2022; 12. WPS LCD L34633- Erythropoiesis Stimulating Agents; Effective 10/01/2015; Revised 7/01/2021; 13 .FCSO LCD L36276- Erythropoiesis Stimulating Agents. Effective 10/01/2015; Revised 9/7/2021; 14. CGS Administrators, LLC, LCA A56462- Billing and Coding: Erythropoiesis Stimulating Agents (ESA), Effective 10/03/2019; Revised 4/7/2022; 15. WPS LCA A56795- Billing and Coding: Erythropoiesis Stimulating Agents; Effective 08/01/2019; Revised 10/01/2021; 16. WPS LCA A57844- Response to Comments: Erythropoiesis Stimulating Agents; Effective 2/9/2020	Complex	12/27/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medicare pays for emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation or levels of service are contraindicated (i.e. would endanger the beneficiary, cause serious impairment to bodily functions or serious dysfunction of any body organ or part). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, and not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted or denied.	0175 - Emergency Ambulance Services – Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 11. 42 CFR 410.40- Coverage of ambulance services, (a) Definitions, (c) Levels of service, and (e)(1) and (3) Medical necessity requirements; 12. 42 CFR 410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements; 13. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services that are not Reasonable and Necessary; 14. 42 CFR 424.36- Signature Requirements; 15. 42 CFR 414.605 Definitions; 16. 42 CFR 414.610 Basis of Payment; 17. 42 CFR 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 18. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 19. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20. Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.4 – Additional Introductory Guidelines, §20.5 – Documentation Requirements, and §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21. Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22. Novitas LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/20105, Revised 10/01/2020; 23. First Coast Service Options (FCSO), LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 24. FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services, Effective Date 6/28/2018, Revised 11/28/2019; 25. FCSO LCA A57674, Billing and Coding: Emergency and Non-Emergency Ground Ambulance Services, Effective 10/03/18; 26. Palmetto, LCD L34549, Ambulance Services, Effective 10/01/15, Revised 07/29/21; 27. Palmetto, LCA A56468, Billing and Coding Ambulance Services, Effective	Complex	1/22/2020	Approved
Medicare pays for emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation or levels of service are contraindicated (i.e. would endanger the beneficiary, cause serious impairment to bodily functions or serious dysfunction of any body organ or part). The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. The level of service is determined based on the patient's condition, and not the vehicle used. Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage requirements will be adjusted or denied.	0175 - Emergency Ambulance Services – Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 11. 42 CFR 410.40- Coverage of ambulance services, (a) Definitions, (c) Levels of service, and (e)(1) and (3) Medical necessity requirements; 12. 42 CFR 410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements; 13. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services that are not Reasonable and Necessary; 14. 42 CFR 424.36- Signature Requirements; 15. 42 CFR 414.605 Definitions; 16. 42 CFR 414.610 Basis of Payment; 17. 42 CFR 424.37 Evidence of Authority to Sign In on behalf of the Beneficiary; 18. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 19. Medicare Benefit Policy Manual, Chapter 10- Ambulance Services, §10- Ambulance Service, §20- Coverage Guidelines for Ambulance Service Claims, §30.1.1- Ground Ambulance Services; 20. Medicare Claims Processing Manual, Chapter 15- Ambulance, §10.4 – Additional Introductory Guidelines, §20.5 – Documentation Requirements, and §30- General Billing Guidelines, (A)- Modifiers Specific to Ambulance Service Claims and (B)- HCPCS Codes; 21. Novitas LCD L35162, Ambulance Services (Ground Ambulance), Effective Date 10/01/2015, Revised 01/01/2020; 22. Novitas LCA A54574, Billing and Coding: Ambulance Services (Ground Ambulance), Effective 10/01/20105, Revised 10/01/2020; 23. First Coast Service Options (FCSO), LCA A52588, Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased. Effective Date 10/01/2015; 24. FCSO, LCD L37697, Emergency and Non-Emergency Ground Ambulance Services, Effective Date 6/28/2018, Revised 11/28/2019; 25. FCSO LCA A57674, Billing and Coding: Emergency and Non-Emergency Ground Ambulance Services, Effective 10/03/18; 26. Palmetto, LCD L34549, Ambulance Services, Effective 10/01/15, Revised 07/29/21; 27. Palmetto, LCA A56468, Billing and Coding Ambulance Services, Effective	Complex	1/22/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Claims for HCPCS code G0402- Initial Preventative Physical Examination (IPPE), billed more than once in a lifetime, or after the initial 12 months or 12 months after the effective date of the beneficiary's first part B coverage period will be denied. Claims for HCPCS code G0438- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); initial, billed more than once in a lifetime will be denied. Claims for HCPCS code G0439- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); subsequent, billed more than once within 12 months of G0438 or G0439 will be denied.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection (hhh); 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (hhh)- Annual Wellness Visit; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §§ 410.15 - Annual Wellness Visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 8. 42 CFR §§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage; 9. 42 CFR § 411.15 - Particular services excluded from coverage, (a) Routine physical checkups such as:(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, Initial Preventive Physical Examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) (k) Any services that are not reasonable and necessary for one of the following purpose: (15) In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in §410.64 of this chapter; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare Benefit Policy Manual- Chapter 15- Covered Medical and Other Health Services, §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 12. Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 13. Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 100.1.1 Evaluation and Management (E/M) Services -(C) Exception for E/M Services Furnished in Certain Primary Care Centers; 14. Medicare Claims Processing Manual- Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit; 15. AMA HCPCS/CPT Codebook	Complex	1/23/2020	Approved
Claims for HCPCS code G0402- Initial Preventative Physical Examination (IPPE), billed more than once in a lifetime, or after the initial 12 months or 12 months after the effective date of the beneficiary's first part B coverage period will be denied. Claims for HCPCS code G0438- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); initial, billed more than once in a lifetime will be denied. Claims for HCPCS code G0439- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); subsequent, billed more than once within 12 months of G0438 or G0439 will be denied.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (S)(2)(FF)- Medical and other health services- personalized prevention plan services (as defined in subsection (hhh); 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (hhh)- Annual Wellness Visit; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §§ 410.15 - Annual Wellness Visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage; 8. 42 CFR §§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage; 9. 42 CFR § 411.15 - Particular services excluded from coverage, (a) Routine physical checkups such as:(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, ultrasound screening for abdominal aortic aneurysms (AAA), cardiovascular disease screening tests, diabetes screening tests, a screening electrocardiogram, Initial Preventive Physical Examinations that meet the criteria specified in paragraphs (k)(6) through (k)(15) (k) Any services that are not reasonable and necessary for one of the following purpose: (15) In the case of additional preventive services not otherwise described in this title, subject to the conditions and limitation specified in §410.64 of this chapter; 10. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 11. Medicare Benefit Policy Manual- Chapter 15- Covered Medical and Other Health Services, §280.5- Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS); 12. Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV]; 13. Medicare Claims Processing Manual- Chapter 12- Physicians/Nonphysician Practitioners, Section 100.1.1 Evaluation and Management (E/M) Services -(C) Exception for E/M Services Furnished in Certain Primary Care Centers; 14. Medicare Claims Processing Manual- Chapter 18 (Preventive and Screening Services), §140- Annual Wellness Visit; 15. AMA HCPCS/CPT Codebook	Complex	1/23/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The focus of this issue is to target claims where a potential overpayment exists when the definition of the procedure code includes imaging and the imaging was billed separately and paid.	0179 - Procedures that Include Imaging: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual: 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; 9. Medicare Claims Processing Manual: 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; 10. Medicare Claims Processing Manual: Chapter 12 -Physicians/Nonphysician Practitioners, §30.6.13 Nursing Facility Services, (A) Visits to Perform the Initial Comprehensive Assessment and Annual Assessments	Automated	3/4/2020	Approved
The focus of this issue is to target claims where a potential overpayment exists when the definition of the procedure code includes imaging and the imaging was billed separately and paid.	0179 - Procedures that Include Imaging: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual: 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; 9. Medicare Claims Processing Manual: 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; 10. Medicare Claims Processing Manual: Chapter 12 -Physicians/Nonphysician Practitioners, §30.6.13 Nursing Facility Services, (A) Visits to Perform the Initial Comprehensive Assessment and Annual Assessments	Automated	3/4/2020	Approved
CPT Codes with a Multiple Procedure Indicator of "6" are subject to a 25% reduction of the Technical Component (TC) when multiple procedures are billed on the same date of service, for the same patient, by the same physician, on the same claim. Claims incorrectly processed will be re-priced with the 25% reduction and the overpaid amount will be recovered. If the CPT code has a Multiple Procedure Indicator of '6' then 75% of the TC portion (Codes with an Indicator of '1') will be allowed and if the PC/TC Indicator is '3' (Technical component only codes) 75% of the Full Fee Schedule for that code will be allowed.	0182 - Reduction of Technical Component Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6. Medicare Claims Processing Manual, Chapter 23, §30.2- Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf Note: Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html; 7. CMS Transmittal 1149 – Change Request 7848, Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf; 8. PFS (Physician Fee Schedule) Relative Value Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	Automated	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT Codes with a Multiple Procedure Indicator of “6” are subject to a 25% reduction of the Technical Component (TC) when multiple procedures are billed on the same date of service, for the same patient, by the same physician, on the same claim. Claims incorrectly processed will be re-priced with the 25% reduction and the overpaid amount will be recovered. If the CPT code has a Multiple Procedure Indicator of ‘6’ then 75% of the TC portion (Codes with an Indicator of ‘1’) will be allowed and if the PC/TC Indicator is ‘3’ (Technical component only codes) 75% of the Full Fee Schedule for that code will be allowed.	0182 - Reduction of Technical Component Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; §3.3.1.3 – Automated Reviews; 6. Medicare Claims Processing Manual, Chapter 23, §30.2- Fee Schedule Administration and Coding Requirements – Addendum - MPFSDB Record Layouts https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf Note: Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html; 7. CMS Transmittal 1149 – Change Request 7848, Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf; 8. PFS (Physician Fee Schedule) Relative Value Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html	Automated	8/3/2020	Approved
Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training. Medical documentation for SCT will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage and documentation requirements will be denied.	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.929- Post-Payment Review; 8. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 9. 42 CFR	Complex	8/3/2020	Approved
Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training. Medical documentation for SCT will be reviewed to determine the Medicare defined conditions have been met for payment. Claims that do not meet the coverage and documentation	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Definitions of Services, Institutions, Etc.; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.929- Post-Payment Review; 8. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 9. 42 CFR	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
For purposes of coverage under Medicare, Total Hip Arthroplasty (THA), also referred to as joint replacement, have proven to be an important medical advancement. Hip Arthroplasty surgery is most commonly performed for diseases which affect the function of the hip joint (ball (femoral head). Occasionally, there may be a need to redo a THA, often referred to as a revision total hip. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of a total hip replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) hip arthroplasties. The documentation will be reviewed to determine if a THA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto GBA, and Noridian.	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §482.24 - Condition of participation: Medical record services; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provision in an LCD; 11. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13. First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14. First Coast LCA A57765- Billing and Coding: Major Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 01/01/21; 15. First Coast LCA A55899- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018, Retired 07/30/2021; 16. First Coast LCA A57986- Major joint replacement (hip and knee) revision to the Part A and Part B Billing and Coding Article; Effective 02/18/2020, Retired 07/30/2021; 17. Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 18. Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 19. NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 10/10/2019; 20. NGS LCA A57428- Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 21. Palmetto LCD L33456-Total Joint Arthroplasty; Effective 10/01/2015; Revised 07/15/2021; 22. Palmetto LCA A56777- Billing and Coding: Total Joint Arthroplasty; Effective 08/01/2019; Revised 10/17/2019; 23. Noridian LCD L36573- Total Hip Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 24. Noridian LCA A57684- Billing and Coding: Total Hip Arthroplasty; Effective 12/01/2019; 25. Noridian LCD	Complex	8/3/2020	Approved
For purposes of coverage under Medicare, Total Hip Arthroplasty (THA), also referred to as joint replacement, have proven to be an important medical advancement. Hip Arthroplasty surgery is most commonly performed for diseases which affect the function of the hip joint (ball (femoral head). Occasionally, there may be a need to redo a THA, often referred to as a revision total hip. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of a total hip replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) hip arthroplasties. The documentation will be reviewed to determine if a THA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto GBA, and Noridian.	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §482.24 - Condition of participation: Medical record services; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4- Reasonable and Necessary Provision in an LCD; 11. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13. First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14. First Coast LCA A57765- Billing and Coding: Major Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 01/01/21; 15. First Coast LCA A55899- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018, Retired 07/30/2021; 16. First Coast LCA A57986- Major joint replacement (hip and knee) revision to the Part A and Part B Billing and Coding Article; Effective 02/18/2020, Retired 07/30/2021; 17. Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 18. Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019 Revised 11/14/2019; 19. NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 10/10/2019; 20. NGS LCA A57428- Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 21. Palmetto LCD L33456-Total Joint Arthroplasty; Effective 10/01/2015; Revised 07/15/2021; 22. Palmetto LCA A56777- Billing and Coding: Total Joint Arthroplasty; Effective 08/01/2019; Revised 10/17/2019; 23. Noridian LCD L36573- Total Hip Arthroplasty; Effective 09/07/2016; Revised 12/01/2019; 24. Noridian LCA A57684- Billing and Coding: Total Hip Arthroplasty; Effective 12/01/2019; 25. Noridian LCD	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
For purposes of coverage under Medicare, Total Knee Arthroplasty (TKA), also referred to as a joint replacement, has proven to be an important medical advancement. Knee Arthroplasty is most commonly performed for diseases which affect the function of the knee joint (the lower end of the femur, the upper end of the tibia and patella). Occasionally, there may be a need to redo a TKA, often referred to as a revision total knee. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of total knee replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) knee arthroplasties. The documentation will be reviewed to determine if a TKA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto, and Noridian.	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambultory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §482.24 - Condition of participation: Medical record services; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4-Reasonable and Necessary Provision in an LCD; 11. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13. First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14. First Coast LCA A57765- Billing and Coding: Major Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 01/01/21; 15. First Coast LCA A55899- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018; Retired 07/30/21; 16. First Coast LCA A57986- Major joint replacement (hip and knee) revision to the Part A and Part B Billing and Coding Article; Effective 02/18/2020; Retired 07/30/21; 17. First Coast LCA A56153- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018; Retired 07/30/2021; 18. Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 19. Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019; Revised 11/14/2019; 20. NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 10/10/2019; 21. NGS LCA A57428- Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 22. Palmetto LCD L33456-Total Joint Arthroplasty; Effective 10/01/2015; Revised 07/15/21; 23. Palmetto LCA A56777- Billing and Coding: Total Joint Arthroplasty; Effective 08/01/2019; Revised 10/17/2019; 24. Noridian LCD L36575- Total Knee Arthroplasty; Effective	Complex	8/3/2020	Approved
For purposes of coverage under Medicare, Total Knee Arthroplasty (TKA), also referred to as a joint replacement, has proven to be an important medical advancement. Knee Arthroplasty is most commonly performed for diseases which affect the function of the knee joint (the lower end of the femur, the upper end of the tibia and patella). Occasionally, there may be a need to redo a TKA, often referred to as a revision total knee. In revisional surgery it is important to provide replacement of the components of the previous surgery responsible for the failure. The goal of total knee replacement surgery is to relieve pain and improve or increase functional activity of the beneficiary. This review only focuses on total (involving the entire joint) knee arthroplasties. The documentation will be reviewed to determine if a TKA is medically necessary according to the guidelines outlined in the LCDs and LCAs of FCSO, Novitas, NGS, Palmetto, and Noridian.	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambultory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §482.24 - Condition of participation: Medical record services; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysician Practitioners, §40- Surgeons and Global Surgery; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.2.4- Signature Requirements; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.3.1.1- Medical Record Review; 10. Medicare Program Integrity Manual, Chapter 13- Local Coverage Determinations, §13.5.4-Reasonable and Necessary Provision in an LCD; 11. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.2-Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions; 12. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 13. First Coast LCD L33618- Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 01/08/2019; 14. First Coast LCA A57765- Billing and Coding: Major Joint Replacement (Hip and Knee); Effective 10/03/2018; Revised 01/01/21; 15. First Coast LCA A55899- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 02/15/2018; Retired 07/30/21; 16. First Coast LCA A57986- Major joint replacement (hip and knee) revision to the Part A and Part B Billing and Coding Article; Effective 02/18/2020; Retired 07/30/21; 17. First Coast LCA A56153- Major joint replacement (hip and knee) revision to the Part A and Part B LCD; Effective 10/01/2018; Retired 07/30/2021; 18. Novitas LCD L36007- Lower Extremity Major Joint Replacement (Hip and Knee); Effective 10/01/2015; Revised 11/14/2019; 19. Novitas LCA A56796- Billing and Coding: Lower Extremity Major Joint Replacement (Hip and Knee); Effective 08/08/2019; Revised 11/14/2019; 20. NGS LCD L36039-Total Joint Arthroplasty; Effective 12/01/2015; Revised 10/10/2019; 21. NGS LCA A57428- Billing and Coding: Total Joint Arthroplasty; Effective 10/10/2019; 22. Palmetto LCD L33456-Total Joint Arthroplasty; Effective 10/01/2015; Revised 07/15/21; 23. Palmetto LCA A56777- Billing and Coding: Total Joint Arthroplasty; Effective 08/01/2019; Revised 10/17/2019; 24. Noridian LCD L36575- Total Knee Arthroplasty; Effective	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This review will determine if a duplex scan of the extracranial arteries was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 42 CFR §410.32(a)- Ordering Diagnostic Tests; 9. 42 CFR §410.32(b)- Diagnostic x-ray and other diagnostic tests; 10. 42 CFR §410.33- Independent Diagnostic Testing Facility; 11. National Coverage Determinations Manual, Chapter 1, Part 1, §20.17- Noninvasive Tests of Carotid Function; 12. National Coverage Determinations Manual, Chapter 1, Part 4, §220.5- Ultrasound Diagnostic Procedures; 13. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 –3.6 .6; 14. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §10.1 - Billing Part B Radiology Services and Other Diagnostic Procedures; 15. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; 16. CGS LCD L34045: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/20/2021; 17. First Coast LCD L33695: Non-Invasive Extracranial Arterial Studies; Effective 10/01/2015; Revised 01/08/2019; 18. NGS LCD L33627: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/01/2019; 19. Noridian LCD L34221: Noninvasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/01/2019; Retired 5/11/2020; 20. Novitas LCD L35397: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 10/17/2019; 21. WPS LCD L35753: Non-Invasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/1/2021; 22. CGS LCA A56697: Billing and Coding: Non-Invasive Vascular Studies; Effective 07/11/2019; Revision Effective: 10/21/2021; 23. First Coast LCA A57670: Billing and Coding: Non-Invasive Extracranial Arterial Studies; Effective 10/03/2018; 24. NGS LCA A56758: Billing and Coding: Non-Invasive Vascular Studies; Effective 08/01/2019; Revised 01/01/2020, 03/01/2020, 10/01/2020; Revised Effective Date 02/25/2021; 25. Noridian LCA A57199: Billing and Coding: Noninvasive Cerebrovascular Studies; Effective 10/01/2019; Retired 5/11/2020; 26. Novitas LCA A52992: Billing and Coding: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 8/02/2019; 27. WPS LCA A57592: Billing and Coding: Non-Invasive Cerebrovascular Studies; Effective 11/01/2019; Revisions	Complex	8/3/2020	Approved
This review will determine if a duplex scan of the extracranial arteries was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 42 CFR §410.32(a)- Ordering Diagnostic Tests; 9. 42 CFR §410.32(b)- Diagnostic x-ray and other diagnostic tests; 10. 42 CFR §410.33- Independent Diagnostic Testing Facility; 11. National Coverage Determinations Manual, Chapter 1, Part 1, §20.17- Noninvasive Tests of Carotid Function; 12. National Coverage Determinations Manual, Chapter 1, Part 4, §220.5- Ultrasound Diagnostic Procedures; 13. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.1 –3.6 .6; 14. Medicare Claims Processing Manual, Chapter 13- Radiology Services and Other Diagnostic Procedures, §10.1 - Billing Part B Radiology Services and Other Diagnostic Procedures; 15. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; 16. CGS LCD L34045: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/20/2021; 17. First Coast LCD L33695: Non-Invasive Extracranial Arterial Studies; Effective 10/01/2015; Revised 01/08/2019; 18. NGS LCD L33627: Non-Invasive Vascular Studies; Effective 10/01/2015; Revised 10/01/2019; 19. Noridian LCD L34221: Noninvasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/01/2019; Retired 5/11/2020; 20. Novitas LCD L35397: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 10/17/2019; 21. WPS LCD L35753: Non-Invasive Cerebrovascular Studies; Effective 10/01/2015; Revised 10/1/2021; 22. CGS LCA A56697: Billing and Coding: Non-Invasive Vascular Studies; Effective 07/11/2019; Revision Effective: 10/21/2021; 23. First Coast LCA A57670: Billing and Coding: Non-Invasive Extracranial Arterial Studies; Effective 10/03/2018; 24. NGS LCA A56758: Billing and Coding: Non-Invasive Vascular Studies; Effective 08/01/2019; Revised 01/01/2020, 03/01/2020, 10/01/2020; Revised Effective Date 02/25/2021; 25. Noridian LCA A57199: Billing and Coding: Noninvasive Cerebrovascular Studies; Effective 10/01/2019; Retired 5/11/2020; 26. Novitas LCA A52992: Billing and Coding: Non-invasive Cerebrovascular Arterial Studies; Effective 10/01/2015; Revised 8/02/2019; 27. WPS LCA A57592: Billing and Coding: Non-Invasive Cerebrovascular Studies; Effective 11/01/2019; Revisions	Complex	8/3/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Medical documentation will be reviewed to determine if the use of nerve conduction studies meets Medicare coverage criteria and is reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 4. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.23- Sensory Nerve Conduction Threshold Tests (sNCTs); 7. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Effective 01/01/2019; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. CGS, Local Coverage Determination L35897- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 04/29/2021; 10. First Coast Local Coverage Determination L34859- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/01/2019; 11. NGS, Local Coverage Determination L35098- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 11/21/2019; 12. Noridian Healthcare Solutions, LLC, Local Coverage Determination L36524- Nerve Conduction Studies and Electromyography; Effective: 06/01/16; Revised 12/01/2019; 13. Noridian Healthcare Solutions, LLC, Local Coverage Determination L36526- Nerve Conduction Studies and Electromyography; Effective: 06/01/2016; Revised 12/01/2019; 14. Novitas Solutions, Inc., Local Coverage Determination L35081- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 15. Palmetto GBA Local Coverage Determination L35048- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 07/15/2021; 16. WPS Local Coverage Determination L34594- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 17. CGS, Local Coverage Article A57307- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 9/26/2019; Revised 10/01/2020 10/01/2021; 18. First Coast Local Coverage Article A57123- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 10/03/2018; Revised 01/01/2021; 19. First Coast Local Coverage Article A56035- Nerve Conduction Studies and Electromyography-Revision to the Part A and Part B LCD; Effective: 5/31/2018, Retired 09/24/2021; 20. NGS, Local Coverage Article A57668-Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 11/21/2019; Revised 10/01/2021; 21. Noridian Healthcare Solutions, LLC, Local Coverage Article A54969- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 6/01/2016; Revised 10/01/2021; 22. Noridian Healthcare Solutions, LLC, Local Coverage Article	Complex	9/25/2020	Approved
Medical documentation will be reviewed to determine if the use of nerve conduction studies meets Medicare coverage criteria and is reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 4. 42 Code of Federal Regulations (CFR) §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, and Reviews; 5. 42 Code of Federal Regulations (CFR) §405.986- Good Cause for Reopening; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.23- Sensory Nerve Conduction Threshold Tests (sNCTs); 7. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80- Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Effective 01/01/2019; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. CGS, Local Coverage Determination L35897- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 04/29/2021; 10. First Coast Local Coverage Determination L34859- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/01/2019; 11. NGS, Local Coverage Determination L35098- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 11/21/2019; 12. Noridian Healthcare Solutions, LLC, Local Coverage Determination L36524- Nerve Conduction Studies and Electromyography; Effective: 06/01/16; Revised 12/01/2019; 13. Noridian Healthcare Solutions, LLC, Local Coverage Determination L36526- Nerve Conduction Studies and Electromyography; Effective: 06/01/2016; Revised 12/01/2019; 14. Novitas Solutions, Inc., Local Coverage Determination L35081- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 15. Palmetto GBA Local Coverage Determination L35048- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 07/15/2021; 16. WPS Local Coverage Determination L34594- Nerve Conduction Studies and Electromyography; Effective: 10/01/2015; Revised 10/31/2019; 17. CGS, Local Coverage Article A57307- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 9/26/2019; Revised 10/01/2020 10/01/2021; 18. First Coast Local Coverage Article A57123- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 10/03/2018; Revised 01/01/2021; 19. First Coast Local Coverage Article A56035- Nerve Conduction Studies and Electromyography-Revision to the Part A and Part B LCD; Effective: 5/31/2018, Retired 09/24/2021; 20. NGS, Local Coverage Article A57668-Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 11/21/2019; Revised 10/01/2021; 21. Noridian Healthcare Solutions, LLC, Local Coverage Article A54969- Billing and Coding: Nerve Conduction Studies and Electromyography; Effective: 6/01/2016; Revised 10/01/2021; 22. Noridian Healthcare Solutions, LLC, Local Coverage Article	Complex	9/25/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0190 - Skilled Nursing Facility with Patient-Driven Payment Model: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1814(a)(2)- Conditions of and Limitations on Payment for Services; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §409.30- Basic Requirements; 9. 42 CFR §409.31- Level of care requirement; 10. 42 CFR §409.32- Criteria for skilled services and the need for skilled services; 11. 42 CFR §409.33- Examples of skilled nursing and rehabilitation services; 12. 42 CFR §409.34- Criteria for "daily basis"; 13. 42 CFR §409.35- Criteria for "practical matter"; 14. 42 CFR §409.36- Effect of discharge from posthospital SNF care; 15. 42 CFR §411.15(p)- Services furnished to SNF residents; 16. 42 CFR §413.337- Methodology for calculating the prospective payment rates; 17. 42 CFR §413.343- Resident Assessment data; 18. 42 CFR §424.11(b)- Obtaining the certification and recertification statements; 19. 42 CFR §424.20- Requirements for posthospital SNF care; 20. 42 CFR §483.20- Resident assessment; 21. Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40- Certification and Recertification by Physicians for Extended Care Services; 22. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 23. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Claims; §6.1.4- Medical Review Process; §6.3 Medical Review of Certification and Recertification of Residents in SNF; 24. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §30- SNF PPS Services; §120- Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM); 25. Medicare Claims Processing Manual, Chapter 25- Completing and Processing the Form CMS-1450 Data Set; 26. Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 27. 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; 28. MDS 3.0 RAI Manual, October 2019	Complex	7/20/2022	Approved
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0190 - Skilled Nursing Facility with Patient-Driven Payment Model: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1814(a)(2)- Conditions of and Limitations on Payment for Services; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §409.30- Basic Requirements; 9. 42 CFR §409.31- Level of care requirement; 10. 42 CFR §409.32- Criteria for skilled services and the need for skilled services; 11. 42 CFR §409.33- Examples of skilled nursing and rehabilitation services; 12. 42 CFR §409.34- Criteria for "daily basis"; 13. 42 CFR §409.35- Criteria for "practical matter"; 14. 42 CFR §409.36- Effect of discharge from posthospital SNF care; 15. 42 CFR §411.15(p)- Services furnished to SNF residents; 16. 42 CFR §413.337- Methodology for calculating the prospective payment rates; 17. 42 CFR §413.343- Resident Assessment data; 18. 42 CFR §424.11(b)- Obtaining the certification and recertification statements; 19. 42 CFR §424.20- Requirements for posthospital SNF care; 20. 42 CFR §483.20- Resident assessment; 21. Medicare General Information, Eligibility and Entitlement Manual, Chapter 4- Physician Certification and Recertification of Services, §40- Certification and Recertification by Physicians for Extended Care Services; 22. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 23. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.1- Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Claims; §6.1.4- Medical Review Process; §6.3 Medical Review of Certification and Recertification of Residents in SNF; 24. Medicare Claims Processing Manual, Chapter 6- SNF Inpatient Part A Billing and SNF Consolidated Billing, §30- SNF PPS Services; §120- Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM); 25. Medicare Claims Processing Manual, Chapter 25- Completing and Processing the Form CMS-1450 Data Set; 26. Medicare Benefit Policy Manual, Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance, §20- Prior Hospitalization and Transfer Requirements, §30- Skilled Nursing Facility Level of Care- General, §40- Physician Certification and Recertification for Extended Care Services; 27. 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; 28. MDS 3.0 RAI Manual, October 2019	Complex	7/20/2022	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record. When the documentation does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 4, §240.4.1- Sleep Testing for Obstructive Sleep Apnea (OSA); 7. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §70- Sleep Disorder Clinics; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 10. CGS Administrators, LLC, LCD L36902- Polysomnography and Other Sleep Studies; Effective 3/6/2017; Revised 01/28/2021; 11. First Coast Service Options, Inc., LCD L33405- Polysomnography and Sleep Testing; Effective 10/01/2015; Revised 7/01/2020; 12. Noridian Healthcare Solutions, LLC, LCD L34040- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Revised 12/01/2019; 13. Noridian Healthcare Solutions, LLC, LCD L36861- Polysomnography and Other Sleep Studies; Effective 06/05/2017; Revised 12/01/2019; 14. Novitas Solutions, Inc., LCD L35050- Outpatient Sleep Studies; Effective 10/01/2015; Revised 01/01/2021; 15. Palmetto GBA, LCD L36593- Polysomnography; Effective 6/13/2016; Revised 10/14/2021; 16. WPS, LCD L36839- Polysomnography and Other Sleep Studies; Effective 2/16/2017; Revised 11/01/2019, Revision effective 7/29/2021; 17. CGS Administrators, LCA A57049- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 9/26/2019; Revised 01/28/2021; 18. First Coast Service Options, Inc., LCA A57496- Billing and Coding: Polysomnography and Sleep Testing; Effective 10/03/2018; Revised 07/07/21; 19. National Government Services, Inc., LCA A53019- Polysomnography and Sleep Studies- Medical Policy Article; Effective 10/01/2015; Revised 10/31/2019; 20. Noridian Healthcare Solutions, LLC, LCA A57697- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 21. Noridian Healthcare Solutions, LLC, LCA A57698- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 22. Noridian Healthcare Solutions, LLC, LCA A55307- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Retired 5/14/2020; 23. Noridian Healthcare Solutions, LLC, LCA A55308- Polysomnography and Other Sleep Studies; Effective	Complex	9/24/2020	Approved
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record. When the documentation does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 6. Medicare National Coverage Determination Manual, Chapter 1, Part 4, §240.4.1- Sleep Testing for Obstructive Sleep Apnea (OSA); 7. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §70- Sleep Disorder Clinics; 8. Medicare Benefit Policy Manual, Chapter 15- Covered Medical and Other Health Services, §80.6- Requirements for Ordering and Following Orders for Diagnostic Tests; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 10. CGS Administrators, LLC, LCD L36902- Polysomnography and Other Sleep Studies; Effective 3/6/2017; Revised 01/28/2021; 11. First Coast Service Options, Inc., LCD L33405- Polysomnography and Sleep Testing; Effective 10/01/2015; Revised 7/01/2020; 12. Noridian Healthcare Solutions, LLC, LCD L34040- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Revised 12/01/2019; 13. Noridian Healthcare Solutions, LLC, LCD L36861- Polysomnography and Other Sleep Studies; Effective 06/05/2017; Revised 12/01/2019; 14. Novitas Solutions, Inc., LCD L35050- Outpatient Sleep Studies; Effective 10/01/2015; Revised 01/01/2021; 15. Palmetto GBA, LCD L36593- Polysomnography; Effective 6/13/2016; Revised 10/14/2021; 16. WPS, LCD L36839- Polysomnography and Other Sleep Studies; Effective 2/16/2017; Revised 11/01/2019, Revision effective 7/29/2021; 17. CGS Administrators, LCA A57049- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 9/26/2019; Revised 01/28/2021; 18. First Coast Service Options, Inc., LCA A57496- Billing and Coding: Polysomnography and Sleep Testing; Effective 10/03/2018; Revised 07/07/21; 19. National Government Services, Inc., LCA A53019- Polysomnography and Sleep Studies- Medical Policy Article; Effective 10/01/2015; Revised 10/31/2019; 20. Noridian Healthcare Solutions, LLC, LCA A57697- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 21. Noridian Healthcare Solutions, LLC, LCA A57698- Billing and Coding: Polysomnography and Other Sleep Studies; Effective 12/01/2019; 22. Noridian Healthcare Solutions, LLC, LCA A55307- Polysomnography and Other Sleep Studies; Effective 10/01/2015; Retired 5/14/2020; 23. Noridian Healthcare Solutions, LLC, LCA A55308- Polysomnography and Other Sleep Studies; Effective	Complex	9/24/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
A ventricular assist device (VAD) is surgically attached to one or both intact ventricles and is used to assist or augment the ability of a damaged or weakened native heart to pump blood. Improvement in the performance of the native heart may allow the device to be removed. The documentation will be reviewed to determine if a left ventricular assist device (LVAD) was placed for a Medicare-covered indication.	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §121.1-121.13-Organ Procurement and Transplantation Network; 8. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. Medicare National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §20.9.1 - Ventricular Assist Devices; 11. Palmetto GBA A53988 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 01/01/2021; 12. Palmetto GBA A53986 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 01/01/2021; 13. Annual American Medical Association: CPT Manual; 14. CMS ICD-10 Procedure Coding System	Complex	9/25/2020	Approved
A ventricular assist device (VAD) is surgically attached to one or both intact ventricles and is used to assist or augment the ability of a damaged or weakened native heart to pump blood. Improvement in the performance of the native heart may allow the device to be removed. The documentation will be reviewed to determine if a left ventricular assist device (LVAD) was placed for a Medicare-covered indication.	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A); 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.929- Post-Payment Review; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR §121.1-121.13-Organ Procurement and Transplantation Network; 8. Medicare Benefit Policy Manual, Chapter 16- General Exclusions from Coverage, §20- Services Not Reasonable and Necessary; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 10. Medicare National Coverage Determinations (NCD) Manual, Chapter 1- Coverage Determinations, §20.9.1 - Ventricular Assist Devices; 11. Palmetto GBA A53988 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 01/01/2021; 12. Palmetto GBA A53986 (LCA); Billing and Coding: Percutaneous Ventricular Assist Device, Effective 10/01/2015; Revised 01/01/2021; 13. Annual American Medical Association: CPT Manual; 14. CMS ICD-10 Procedure Coding System	Complex	9/25/2020	Approved
Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the skin substitute applied to the patient, including any appropriate discarded waste. If the quantity of skin substitute applied to the wound used in the treatment plan of a patient is less than a multiple of the defined billing unit for the supported HCPCS code dosage descriptor, the provider must round to the next highest whole unit. The quantity used in the application of the skin substitute is billed on a separate line item than the allowable wastage. The wastage billing line (that corresponds to the discarded portion of a single use package) must be appended with the JW modifier. Documentation must support the service provided with the number of units billed as it correlates to the dosage increment specified in the HCPCS long descriptor. Units billed must also correspond to the actual quantity of skin substitute product applied to the wound during the treatment plan of the patient, including any appropriate discarded waste. The skin substitute product applied in the treatment of the patient must correlate with the appropriately rendered HCPCS code paid.	0193 - Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR § 419.2(b) (16) – Centers for Medicare & Medicaid Services, HHS, (§ 419) Basis of payment; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"; §100.5.4- Post-Payment Overpayment Recovery Actions; 10. Medicare Alpha-Numeric HCPCS File – Alpha-Numeric HCPCS, Centers for Medicare & Medicaid Services; 11. Annual HCPCS Level II Manual - Centers for Medicare & Medicaid Services	Complex	10/1/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the skin substitute applied to the patient, including any appropriate discarded waste. If the quantity of skin substitute applied to the wound used in the treatment plan of a patient is less than a multiple of the defined billing unit for the supported HCPCS code dosage descriptor, the provider must round to the next highest whole unit. The quantity used in the application of the skin substitute is billed on a separate line item than the allowable wastage. The wastage billing line (that corresponds to the discarded portion of a single use package) must be appended with the JW modifier. Documentation must support the service provided with the number of units billed as it correlates to the dosage increment specified in the HCPCS long descriptor. Units billed must also correspond to the actual quantity of skin substitute product applied to the wound during the treatment plan of the patient, including any appropriate discarded waste. The skin substitute product applied in the treatment of the patient must correlate with the appropriately rendered HCPCS code paid.	0193 - Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. 42 CFR § 419.2(b) (16) – Centers for Medicare & Medicaid Services, HHS, (§ 419) Basis of payment; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. Medicare Claims Processing Manual, Chapter 17- Drugs and Biologicals, §10- Payment Rules for Drugs and Biologicals; §40- Discarded Drugs and Biologicals; §70- Claims Processing Requirements- General; §90.2- Drugs, Biologicals, and Radiopharmaceuticals; §100.2.9- Submission of Claims with the Modifier JW, “Drug Amount Discarded/Not Administered to Any Patient”; §100.5.4- Post-Payment Overpayment Recovery Actions; 10. Medicare Alpha-Numeric HCPCS File – Alpha-Numeric HCPCS, Centers for Medicare & Medicaid Services; 11. Annual HCPCS Level II Manual - Centers for Medicare & Medicaid Services	Complex	10/1/2020	Approved
The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Effective January 18, 2017, The Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED). Leadless pacemakers are non-covered when furnished outside of a CMS approved CED study. The documentation will be reviewed to determine if the use of a leadless pacemaker meets Medicare coverage guidelines and applicable coding guidelines.	0194 - Leadless Pacemakers: Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(E)-Exclusions from Coverage and Medicare as a Secondary Payer; 3. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)-Payment of Benefits; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare National Coverage Determination (NCD) Manual, Chapter 1- Coverage Determinations, §20.8.4-Leadless Pacemakers, §310.1- Routine Costs in Clinical Trials; 7. Medicare Claims Processing Manual, Chapter 32-Billing Requirements for Special Services, §380-Leadless Pacemakers, §380.1-Leadless Pacemaker Coding and Billing Requirements for Professional Claims, §380.1.2-Leadless Pacemaker Modifier, §380.1.3-Leadless Pacemaker Additional Claim Billing Information; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §69-Qualifying Clinical Trails-General, §69.1 -General, §69.2-Payment for Qualifying Clinical Trial Services, §69.3 - Medical Records Documentation Requirements, §69.5 -Billing Requirements – General, §69.6-Requirements for Billing Routine Costs of Clinical Trials; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8-No Response or Insufficient Response to Additional Documentation Requests, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 10. Medicare Program Integrity Manual, Chapter 6-Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.4- Review of Procedures Affecting the DRG; 11. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12. Novitas Solutions, Inc., LCD L35094-Services That Are Not Reasonable and Necessary, Effective 10/01/2015, Revised 03/15/2020, Retired 7/1/20; 13. Annual American Medical Association (AMA) CPT Manual; 14. Annual ICD-10-CM Diagnosis Codebook; 15. Annual ICD-10-PCS Procedure Codebook	Complex	10/1/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Effective January 18, 2017, The Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through Coverage with Evidence Development (CED). Leadless pacemakers are non-covered when furnished outside of a CMS approved CED study. The documentation will be reviewed to determine if the use of a leadless pacemaker meets Medicare coverage guidelines and applicable coding guidelines.	0194 - Leadless Pacemakers: Incorrect Coding	Inpatient Hospital, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(E)-Exclusions from Coverage and Medicare as a Secondary Payer; 3. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)-Payment of Benefits; 4. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR §405.986- Good Cause for Reopening; 6. Medicare National Coverage Determination (NCD) Manual, Chapter 1- Coverage Determinations, §20.8.4-Leadless Pacemakers, §310.1- Routine Costs in Clinical Trials; 7. Medicare Claims Processing Manual, Chapter 32-Billing Requirements for Special Services, §380-Leadless Pacemakers, §380.1-Leadless Pacemaker Coding and Billing Requirements for Professional Claims, §380.1.2-Leadless Pacemaker Modifier, §380.1.3-Leadless Pacemaker Additional Claim Billing Information; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §69-Qualifying Clinical Trails-General, §69.1 -General, §69.2-Payment for Qualifying Clinical Trial Services, §69.3 - Medical Records Documentation Requirements, §69.5 -Billing Requirements – General, §69.6-Requirements for Billing Routine Costs of Clinical Trials; 9. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8-No Response or Insufficient Response to Additional Documentation Requests, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 10. Medicare Program Integrity Manual, Chapter 6-Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.4- Review of Procedures Affecting the DRG; 11. Medicare Benefit Policy Manual, Chapter 16- General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12. Novitas Solutions, Inc., LCD L35094-Services That Are Not Reasonable and Necessary, Effective 10/01/2015, Revised 03/15/2020, Retired 7/1/20; 13. Annual American Medical Association (AMA) CPT Manual; 14. Annual ICD-10-CM Diagnosis Codebook; 15. Annual ICD-10-PCS Procedure Codebook	Complex	10/1/2020	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1-Coding Requirements for Implantable Automatic Defibrillators; 10. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 11. Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4-Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 12. First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 13. NGS Local Coverage Article A56326-Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 14. Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 15. Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 16. Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 17. Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 18. WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	10/23/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270- Claims Processing for Implantable Automatic Defibrillators; 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.1- Coding Requirements for Implantable Automatic Defibrillators; 10. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, Section 270.2- Billing Requirements for Patients Enrolled in a Data Collection System; 11. Medicare National Coverage Determinations (NCD) Manual: Chapter 1 – Coverage Determinations, Part 1, Section 20.4- Implantable Cardioverter Defibrillators (ICDs), Effective 2/15/2018; 12. First Coast Local Coverage Article A56341- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 13. NGS Local Coverage Article A56326- Coding and Billing: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 5/7/2020; 14. Noridian Local Coverage Article A56340- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 15. Noridian Local Coverage Article A56342- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2021; 16. Novitas Local Coverage Article A56355- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Retired 7/6/2021; 17. Palmetto Local Coverage Article: A56343- Billing and Coding: Implantable Automatic Defibrillators; Effective 3/26/2019; Revised 10/01/2019; 18. WPS Local Coverage Article A56391- Billing and Coding: Implantable Automatic Defibrillators; Effective 5/13/2019; Revised 10/01/2021	Complex	10/23/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider whether the initial placement of Deep Brain Stimulation is reasonable and necessary for the treatment of Parkinson's disease and Essential Tremor, under certain conditions.	0196 - Deep Brain Stimulation- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.3- Healthcare Common Procedure Coding System (HCPCS); 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	Complex	11/18/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider whether the initial placement of Deep Brain Stimulation is reasonable and necessary for the treatment of Parkinson's disease and Essential Tremor, under certain conditions.	0196 - Deep Brain Stimulation- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.3- Healthcare Common Procedure Coding System (HCPCS); 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	Complex	11/18/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider DBS to be reasonable and necessary for the treatment of Parkinson's disease under certain conditions.	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.2- Allowable Covered Procedure Codes; 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	Complex	11/18/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes produce electrical impulses that regulate abnormal impulses within the brain. The amount of stimulation is controlled by a pacemaker-like device placed under the skin in the chest and connects to the electrodes in the brain. Medicare will consider DBS to be reasonable and necessary for the treatment of Parkinson's disease under certain conditions.	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §50 Deep Brain Stimulation for Essential Tremor and Parkinson's Disease; §50.1- Coverage Requirements; §50.2- Billing Requirements; §50.4.2- Allowable Covered Procedure Codes; 9. Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §160.24 - Deep Brain Stimulation for Essential Tremor and Parkinson's Disease	Complex	11/18/2020	Approved
A distal claviculectomy requires approximately 1 cm (or 8-10 mm) of bone to be removed to report 23120 Claviculectomy; partial or 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure). Documentation will be reviewed to determine that a partial claviculectomy was performed. Services that are not medically reasonable and necessary and/or do not support the procedure code billed may result in an overpayment or underpayment.	0199 - Distal Claviculectomy: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. American Medical Association, CPT® Changes 2002: An Insider's View; 7. National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current; 8. AMA CPT Manual	Complex	11/21/2020	Approved
A distal claviculectomy requires approximately 1 cm (or 8-10 mm) of bone to be removed to report 23120 Claviculectomy; partial or 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure). Documentation will be reviewed to determine that a partial claviculectomy was performed. Services that are not medically reasonable and necessary and/or do not support the procedure code billed may result in an overpayment or underpayment.	0199 - Distal Claviculectomy: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 6. American Medical Association, CPT® Changes 2002: An Insider's View; 7. National Correct Coding Initiative Policy Manual, Chapter 4- Surgery: Musculoskeletal System CPT Codes 20000-29999, E, "Arthroscopy"- Effective January 1, 2014- current; 8. AMA CPT Manual	Complex	11/21/2020	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This purpose of this review is to ensure Medicare coverage criteria for air ambulance transport have been met. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). You may furnish air Medicare ambulance transportation to a beneficiary when all of these criteria are met: •The transportation is medically necessary •Any other means of transportation is contraindicated •A Medicare beneficiary is transported to an acute care hospital This complex review will be examining rotatory wing (helicopter) aircraft claims to determine if air ambulance transport was reasonable and medically necessary as well as whether or not documentation requirements have been met.	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Medical and Other Health Services; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 11. 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service; 12. 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis; 13. 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements; 14. 42 CFR §414.605 Definitions; 15. 42 CFR §414.610 Basis of Payment; 16. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services that are not Reasonable and Necessary; 17. 42 CFR §424.36- Signature Requirements; 18. 42 CFR §424.37- Evidence of Authority to Sign on behalf of the Beneficiary; 19. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 20. Medicare Benefit Policy Manual (MBPM), Chapter 10, Ambulance Services, §10.4 Air Ambulance Services; 21. Medicare Claims Processing Manual, Chapter 15, Ambulance, §20.3 Air Ambulance; 22. Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.17(C) Ambulance Transports	Complex	2/4/2021	Approved
This purpose of this review is to ensure Medicare coverage criteria for air ambulance transport have been met. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). You may furnish air Medicare ambulance transportation to a beneficiary when all of these criteria are met: •The transportation is medically necessary •Any other means of transportation is contraindicated •A Medicare beneficiary is transported to an acute care hospital This complex review will be examining rotatory wing (helicopter) aircraft claims to determine if air ambulance transport was reasonable and medically necessary as well as whether or not documentation requirements have been met.	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861(s)(7)- Medical and Other Health Services; 4. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (v)(1)(K)(ii) – Reasonable Cost; 5. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834(l) (10)-(16)- Establishment of Fee Schedule for Ambulance Services; 6. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 7. 42 CFR §405.986- Good Cause for Reopening; 8. 42 CFR §405.929- Post-Payment Review; 9. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 10. 42 CFR §424.5- Basic Conditions, (a)(6) Sufficient Information; 11. 42 CFR §410.40- Coverage of ambulance services, (c) Levels of service; 12. 42 CFR §410.40- Coverage of ambulance services, (e) Medical necessity requirements (1) General Rule and (3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis; 13. 42 CFR §410.41- Requirements for ambulance providers and suppliers, (c) Billing and reporting requirements; 14. 42 CFR §414.605 Definitions; 15. 42 CFR §414.610 Basis of Payment; 16. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)(1) Any Services that are not Reasonable and Necessary; 17. 42 CFR §424.36- Signature Requirements; 18. 42 CFR §424.37- Evidence of Authority to Sign on behalf of the Beneficiary; 19. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 20. Medicare Benefit Policy Manual (MBPM), Chapter 10, Ambulance Services, §10.4 Air Ambulance Services; 21. Medicare Claims Processing Manual, Chapter 15, Ambulance, §20.3 Air Ambulance; 22. Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections, §50.17(C) Ambulance Transports	Complex	2/4/2021	Approved
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay. A denial of services will result in an overpayment.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 42 CFR § 409.27(c) – Other services generally provided by (or under arrangements made by) SNF; 9. General Explanation of the Major Categories I. – V. for Skilled Nursing Facility (SNF) Consolidated Billing – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index; 10. Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1 - Ambulance Services	Automated	2/4/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay. A denial of services will result in an overpayment.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. 42 CFR § 409.27(c) – Other services generally provided by (or under arrangements made by) SNF; 9. General Explanation of the Major Categories I. – V. for Skilled Nursing Facility (SNF) Consolidated Billing – https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index; 10. Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing, § 20.3.1 - Ambulance Services	Automated	2/4/2021	Approved
Payment for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures is determined based on the base unit of the anesthesia procedure with the highest base unit value, and time units based on the actual anesthesia time of the multiple procedures. Incorrectly paid codes will be re-priced based on the correct conversion factor calculations and recovered as overpayments.	0203 - Anesthesia Associated with Multiple Surgeries: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12, §50 – Payment for Anesthesiology Services; §140.3.2 – Anesthesia Time and Calculation of Anesthesia Time Units; §140.3.3 – Billing Modifiers; 9. CMS Anesthesiologists Center – Anesthesia Conversion Factors- https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html	Automated	3/3/2021	Approved
Payment for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures is determined based on the base unit of the anesthesia procedure with the highest base unit value, and time units based on the actual anesthesia time of the multiple procedures. Incorrectly paid codes will be re-priced based on the correct conversion factor calculations and recovered as overpayments.	0203 - Anesthesia Associated with Multiple Surgeries: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare Claims Processing Manual, Chapter 12, §50 – Payment for Anesthesiology Services; §140.3.2 – Anesthesia Time and Calculation of Anesthesia Time Units; §140.3.3 – Billing Modifiers; 9. CMS Anesthesiologists Center – Anesthesia Conversion Factors- https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html	Automated	3/3/2021	Approved
Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. VNS is not reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed. VNS is reasonable and necessary for treatment-resistant depression through Coverage with Evidence Development (CED). VNS for treatment of resistant depression is non-covered when furnished outside of a CMS-approved CED study. Medical documentation will be reviewed to determine if the vagus nerve stimulator meets Medicare coverage criteria and/or is reasonable and necessary. Denied services will result in an overpayment.	0204 - Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2, 160.18- Vagus Nerve Stimulation (VNS); 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §200- Billing Requirements for Vagus Nerve Stimulation (VNS); 10. Annual American Medical Association: CPT Manual; 11. CMS ICD-10 Procedure Coding System	Complex	3/11/2021	Approved
Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. VNS is not reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed. VNS is reasonable and necessary for treatment-resistant depression through Coverage with Evidence Development (CED). VNS for treatment of resistant depression is non-covered when furnished outside of a CMS-approved CED study. Medical documentation will be reviewed to determine if the vagus nerve stimulator meets Medicare coverage criteria and/or is reasonable and necessary. Denied services will result in an overpayment.	0204 - Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 6. 42 CFR §405.986- Good Cause for Reopening; 7. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 8. Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2, 160.18- Vagus Nerve Stimulation (VNS); 9. Medicare Claims Processing Manual, Chapter 32- Billing Requirements for Special Services, §200- Billing Requirements for Vagus Nerve Stimulation (VNS); 10. Annual American Medical Association: CPT Manual; 11. CMS ICD-10 Procedure Coding System	Complex	3/11/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.986-Good Cause for Reopening; 4. 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR § 410.28- Hospital or CAH diagnostic services furnished to outpatients: Conditions; 6. 42 CFR §410.32-Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions, (a)-Ordering diagnostic tests; 7. 42 CFR §424.5(a)(6)-Sufficient information; 8. 42 CFR §493-Laboratory Requirements, §493.1 Basis and scope; 9. 45 CFR §162.1002(c)-Medical data code sets, for the period on and after October 1, 2015; 10. Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, §80.1 – Clinical Laboratory Services; 11. Medicare Benefit Policy Manual, Chapter 16-General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12. Medicare Claims Processing Manual, Chapter 16- Laboratory Services,§40.7 Billing for Noncovered Clinical Laboratory Tests Section; 13. Medicare Claims Processing Manual, Chapter 30- Financial Liability Protections, §50- Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN), §120.1 - Documentation of Notices Regarding Coverage; 14. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8-No Response or Insufficient Response to Additional Documentation Requests, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 15. Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2- Coverage Determinations, §90.2-Next Generation Sequencing; Effective: 01/27/2020; Implementation: 11/13/2020; 16. Annual American Medical Association (AMA) CPT Manual; 17. Annual ICD-10-CM Manual	Complex	5/29/2021	Approved
Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a treating physician, and when all of the National Coverage Determination (NCD) requirements are met. The documentation will be reviewed to determine if NGS as a diagnostic laboratory test was medically necessary according to the guidelines in the NCD.	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)-Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII-Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.986-Good Cause for Reopening; 4. 42 CFR §405.980-Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)-Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 5. 42 CFR § 410.28- Hospital or CAH diagnostic services furnished to outpatients: Conditions; 6. 42 CFR §410.32-Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions, (a)-Ordering diagnostic tests; 7. 42 CFR §424.5(a)(6)-Sufficient information; 8. 42 CFR §493-Laboratory Requirements, §493.1 Basis and scope; 9. 45 CFR §162.1002(c)-Medical data code sets, for the period on and after October 1, 2015; 10. Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, §80.1 – Clinical Laboratory Services; 11. Medicare Benefit Policy Manual, Chapter 16-General Exclusion from Coverage, §10- General Exclusions from Coverage, §20-Services Not Reasonable and Necessary; 12. Medicare Claims Processing Manual, Chapter 16- Laboratory Services,§40.7 Billing for Noncovered Clinical Laboratory Tests Section; 13. Medicare Claims Processing Manual, Chapter 30- Financial Liability Protections, §50- Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN), §120.1 - Documentation of Notices Regarding Coverage; 14. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8-No Response or Insufficient Response to Additional Documentation Requests, §3.3.1.1- Medical Record Review, §3.6.2.4 Coding Determinations; 15. Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 2- Coverage Determinations, §90.2-Next Generation Sequencing; Effective: 01/27/2020; Implementation: 11/13/2020; 16. Annual American Medical Association (AMA) CPT Manual; 17. Annual ICD-10-CM Manual	Complex	5/29/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered reasonable and necessary when clinical management of the patient would differ depending on the staging of the cancer identified, and in clinical situations in which the stage of the cancer remains in doubt after completing a standard diagnostic workup or it is expected that conventional imaging study information is insufficient for clinical management of the patient. Medical records will be reviewed to determine if the utilization of FDG PET studies for initial anti-tumor treatment strategy are medically necessary according to Medicare coverage indications.	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefit; 3. 42 CFR §405.980 - Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986 - Good Cause for Reopening; 5. 42 CFR §424.5 - Basic Conditions, (a)(6) - Sufficient Information; 6. 42 CFR §411.15 - Particular Services Excluded from Coverage, (k) - Any Services Not Reasonable and Necessary; 7. 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8. National Coverage Determination Manual, Ch. 1, §220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions; 9. Medicare Program Integrity Manual, Ch. 3 - Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 10. Medicare Claims Processing Manual, Ch. 13 - Radiology Services and Other Diagnostic Procedures, §60 - General Information; §60.1 - Billing Instructions, (D)- Post-Payment Review for PET Scans; §60.3.1 - Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; §60.3.2 - Tracer Codes Required for Positron Emission Tomography (PET) Scans; and §60.7 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009; 11. Noridian LCA 54666: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; revised date 10/29/2021; 12. Noridian LCA 54668: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Revised date 10/29/2021; 13. Novitas LCA A53132: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 10/1/2015; Revised date 07/01/2021; 14.First Coast Service Options, Inc LCA A58826: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 04/01/2012; Revised date 07/01/2021	Complex	5/29/2021	Approved
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered reasonable and necessary when clinical management of the patient would differ depending on the staging of the cancer identified, and in clinical situations in which the stage of the cancer remains in doubt after completing a standard diagnostic workup or it is expected that conventional imaging study information is insufficient for clinical management of the patient. Medical records will be reviewed to determine if the utilization of FDG PET studies for initial anti-tumor treatment strategy are medically necessary according to Medicare coverage indications.	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefit; 3. 42 CFR §405.980 - Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c) - Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986 - Good Cause for Reopening; 5. 42 CFR §424.5 - Basic Conditions, (a)(6) - Sufficient Information; 6. 42 CFR §411.15 - Particular Services Excluded from Coverage, (k) - Any Services Not Reasonable and Necessary; 7. 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions; 8. National Coverage Determination Manual, Ch. 1, §220.6.17 Positron Emission Tomography (PET) for Oncologic Conditions; 9. Medicare Program Integrity Manual, Ch. 3 - Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8 - No Response or Insufficient Response to Additional Documentation Requests; 10. Medicare Claims Processing Manual, Ch. 13 - Radiology Services and Other Diagnostic Procedures, §60 - General Information; §60.1 - Billing Instructions, (D)- Post-Payment Review for PET Scans; §60.3.1 - Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005; §60.3.2 - Tracer Codes Required for Positron Emission Tomography (PET) Scans; and §60.7 - Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009; 11. Noridian LCA 54666: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; revised date 10/29/2021; 12. Noridian LCA 54668: Billing and Coding Positron Emission Tomography Scans Coverage. Effective date 10/01/2015; Revised date 10/29/2021; 13. Novitas LCA A53132: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 10/1/2015; Revised date 07/01/2021; 14.First Coast Service Options, Inc LCA A58826: Billing and Coding: NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions. Effective date 04/01/2012; Revised date 07/01/2021	Complex	5/29/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Dorsal Column (Spinal cord) stimulation involves surgical implantation of neurostimulator electrodes within the dura mater (endodural) or percutaneous insertion of electrodes in the epidural space. The implantation consists of two stages: the first stage contains an implantation of neurostimulator electrode(s) and a connection of an external neurostimulator. In some cases, temporary electrodes are used. It is a short trial to assess the patient's suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. If pain relief is achieved, the temporary system may be transitioned to a permanent system. The second stage involves subcutaneous insertion of a permanent neurostimulator with connection of the implanted electrode(s). Spinal cord neurostimulators (SCS) may be covered as therapies for the relief of chronic intractable pain, and medical records will be reviewed to determine if the implantation of SCS meets Medicare coverage criteria and documentation requirements.	0207 - Spinal Cord Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefit; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 7. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation and §160.7 Electrical Nerve Stimulators, (B) Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators); 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, §13.5.4 Reasonable and Necessary Provision in an LCD; 10. First Coast Local Coverage Determination L36035- Spinal Cord Stimulation for Chronic Pain; Effective 10/01/2015; Revised 11/28/2019; 11. First Coast Local Coverage Article A57709- Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 10/03/2018; 12. Novitas Local Coverage Determination L35450- Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 10/01/2015; Revised 09/26/2019; 13. Novitas Local Coverage Article A57023- Billing and Coding: Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 09/26/2019; Revised 09/26/2019; 14. Palmetto Local Coverage Determination L37632- Spinal Cord Stimulators for Chronic Pain; Effective 01/29/2018; Revised 05/13/21; 15. Palmetto Local Coverage Article A56876- Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 08/22/2019; Revised 05/13/21; 16. Cahaba Government Benefit Administrators L36879 – Surgery: Spinal Cord Stimulators for Chronic Pain; Effective 03/01/2017; Retired 02/25/2018; 17. Noridian Local Coverage Determination L36204- Spinal Cord Stimulators for Chronic Pain; Effective 06/01/2016; Revised 12/01/2019; 18. Noridian Local Coverage Determination L35136 – Spinal Cord Stimulators for Chronic Pain; Effective 10/01/2015; Revised 12/01/2019; 19. Noridian Local Coverage Article A57791 – Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 12/01/2019; 20. Noridian Local Coverage Article A57792 – Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 12/01/19; 21. American Hospital Association (AHA) Coding Clinic for HCPCS; 22. American Medical Association (AMA) Current Procedure Terminology Assistant; 23. National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VIII – Surgery: Endocrine,	Complex	5/29/2021	Approved
Dorsal Column (Spinal cord) stimulation involves surgical implantation of neurostimulator electrodes within the dura mater (endodural) or percutaneous insertion of electrodes in the epidural space. The implantation consists of two stages: the first stage contains an implantation of neurostimulator electrode(s) and a connection of an external neurostimulator. In some cases, temporary electrodes are used. It is a short trial to assess the patient's suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. If pain relief is achieved, the temporary system may be transitioned to a permanent system. The second stage involves subcutaneous insertion of a permanent neurostimulator with connection of the implanted electrode(s). Spinal cord neurostimulators (SCS) may be covered as therapies for the relief of chronic intractable pain, and medical records will be reviewed to determine if the implantation of SCS meets Medicare coverage criteria and documentation requirements.	0207 - Spinal Cord Stimulation: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefit; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (c)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Requested by a Party; 4. 42 CFR §405.986- Good Cause for Reopening; 5. 42 CFR §424.5- Basic Conditions, (a)(6)- Sufficient Information; 6. 42 CFR §411.15- Particular Services Excluded from Coverage, (k)- Any Services Not Reasonable and Necessary; 7. Medicare National Coverage Determination Manual, Chapter 1, Part 2, §160.2 Treatment of Motor Function Disorders with Electric Nerve Stimulation and §160.7 Electrical Nerve Stimulators, (B) Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators); 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §3.2.3.8- No Response or Insufficient Response to Additional Documentation Requests; 9. Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations, §13.5.4 Reasonable and Necessary Provision in an LCD; 10. First Coast Local Coverage Determination L36035- Spinal Cord Stimulation for Chronic Pain; Effective 10/01/2015; Revised 11/28/2019; 11. First Coast Local Coverage Article A57709- Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 10/03/2018; 12. Novitas Local Coverage Determination L35450- Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 10/01/2015; Revised 09/26/2019; 13. Novitas Local Coverage Article A57023- Billing and Coding: Spinal Cord Stimulation (Dorsal Column Stimulation); Effective 09/26/2019; Revised 09/26/2019; 14. Palmetto Local Coverage Determination L37632- Spinal Cord Stimulators for Chronic Pain; Effective 01/29/2018; Revised 05/13/21; 15. Palmetto Local Coverage Article A56876- Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 08/22/2019; Revised 05/13/21; 16. Cahaba Government Benefit Administrators L36879 – Surgery: Spinal Cord Stimulators for Chronic Pain; Effective 03/01/2017; Retired 02/25/2018; 17. Noridian Local Coverage Determination L36204- Spinal Cord Stimulators for Chronic Pain; Effective 06/01/2016; Revised 12/01/2019; 18. Noridian Local Coverage Determination L35136 – Spinal Cord Stimulators for Chronic Pain; Effective 10/01/2015; Revised 12/01/2019; 19. Noridian Local Coverage Article A57791 – Billing and Coding: Spinal Cord Stimulators for Chronic Pain; Effective 12/01/2019; 20. Noridian Local Coverage Article A57792 – Billing and Coding: Spinal Cord Stimulation for Chronic Pain; Effective 12/01/19; 21. American Hospital Association (AHA) Coding Clinic for HCPCS; 22. American Medical Association (AMA) Current Procedure Terminology Assistant; 23. National Correct Coding Initiative Policy Manual for Medicare Services, Chapter VIII – Surgery: Endocrine,	Complex	5/29/2021	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Hypoglossal nerve stimulation (HNS) is reasonable and necessary for the treatment of moderate to severe obstructive sleep apnea (OSA) when coverage criteria are met. Documentation will be reviewed to determine if HNS meets Medicare coverage criteria, applicable coding guidelines, and/or are medically reasonable and necessary.	0210 - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Hospital Outpatient; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 4, Section 240.4.1 Sleep Testing for Obstructive Sleep Apnea (OSA) 13; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. Palmetto GBA, LCD L38276- Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea, Effective 06/21/2020; 10. Palmetto GBA, LCA A58075- Billing and Coding: Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea, Effective 06/21/2020; Revised 01/01/2022; 11. First Coast Service Options, Inc., LCD L38398- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 12. First Coast Service Options, Inc., LCA A56953 - Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/16/2020; Revised 01/01/2022; 13. Novitas Solutions, Inc., LCD L38385- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 14. Novitas Solutions, Inc., LCA A56938- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; Revised 01/01/2022; 15. National Government Services, Inc., LCD L38387-Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 04/01/2020; Revised 04/01/2020; 16. National Government Services, Inc., LCA A57092- Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea, Effective 04/01/2020; Revised 01/01/2022; 17. Wisconsin Physicians Service Insurance Corporation, LCD L38528- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 06/14/2020; 18. Wisconsin Physicians Service Insurance Corporation, LCA A57944-Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 06/14/2020; Revised 01/01/2022; 19. Noridian Healthcare Solutions, LLC, LCD L38310(JE)- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 20. Noridian Healthcare Solutions, LLC, LCD L38312(JF)- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 21. Noridian Healthcare Solutions, LLC, LCA A57948(JE)- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; Revised 01/01/2022; 22. Noridian Healthcare Solutions, LLC, LCA A57949(JF)-	Complex	6/29/2022	Approved
Hypoglossal nerve stimulation (HNS) is reasonable and necessary for the treatment of moderate to severe obstructive sleep apnea (OSA) when coverage criteria are met. Documentation will be reviewed to determine if HNS meets Medicare coverage criteria, applicable coding guidelines, and/or are medically reasonable and necessary.	0210 - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Hospital Outpatient; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and Reviews, (b)- Timeframes and Requirements for Reopening Initial Determinations and Redeterminations Initiated by a Contractor; and (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 §405.929- Post-Payment Review; 6. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 7. Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 4, Section 240.4.1 Sleep Testing for Obstructive Sleep Apnea (OSA) 13; 8. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1- 3.6.6; 9. Palmetto GBA, LCD L38276- Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea, Effective 06/21/2020; 10. Palmetto GBA, LCA A58075- Billing and Coding: Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea, Effective 06/21/2020; Revised 01/01/2022; 11. First Coast Service Options, Inc., LCD L38398- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 12. First Coast Service Options, Inc., LCA A56953 - Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/16/2020; Revised 01/01/2022; 13. Novitas Solutions, Inc., LCD L38385- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 14. Novitas Solutions, Inc., LCA A56938- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; Revised 01/01/2022; 15. National Government Services, Inc., LCD L38387-Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 04/01/2020; Revised 04/01/2020; 16. National Government Services, Inc., LCA A57092- Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea, Effective 04/01/2020; Revised 01/01/2022; 17. Wisconsin Physicians Service Insurance Corporation, LCD L38528- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 06/14/2020; 18. Wisconsin Physicians Service Insurance Corporation, LCA A57944-Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 06/14/2020; Revised 01/01/2022; 19. Noridian Healthcare Solutions, LLC, LCD L38310(JE)- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 20. Noridian Healthcare Solutions, LLC, LCD L38312(JF)- Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; 21. Noridian Healthcare Solutions, LLC, LCA A57948(JE)- Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea, Effective 03/15/2020; Revised 01/01/2022; 22. Noridian Healthcare Solutions, LLC, LCA A57949(JF)-	Complex	6/29/2022	Approved