

Cotiviti Approved Issues List as of March 21, 2023

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
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Outpatient Hospital, Inpatient Hospital	61
Outpatient Hospital, Physician	63
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Outpatient Hospital, Physician	68
Physician, Outpatient Hospital, Professional Services	70
Physician, Professional Services	72
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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
WPS 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-DRG 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-DRG Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	1/23/2017	Approved
WPS 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-DRG 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-DRG Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	1/23/2017	Approved
Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0002 - Cataract Removal: Medical Necessity and Documentation Requirements	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	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,	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,	Complex	2/12/2017	Approved
Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory Surgery Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the ADR Letter date	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	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	Complex	5/5/2017	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)	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	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 successful with the medical treatment of obesity. Claims requiring surgical	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	1/23/2017	Approved
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI ≥ 35, have at least one co-morbidity related to obesity and have been previously successful with the medical treatment of obesity. Claims requiring surgical	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	Complex	1/24/2017	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Inpatient	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional	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	Automated	1/29/2017	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if	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	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	0022 - Inpatient Psychiatric Admission Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Automated	2/27/2017	Approved
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 incorrectly used to bill for these services. Denied claims	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	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 incorrectly used to bill for these services. Denied claims	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	Complex	4/3/2017	Approved
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied.	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,	Automated	4/26/2017	Approved
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied.	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,	Automated	4/26/2017	Approved
Both initial Hospital Care codes (CPT codes 99211-99233) 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	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	Automated	3/23/2017	Approved
Both initial Hospital Care codes (CPT codes 99211-99233) 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	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	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	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 2 CFR §405.930- Failure to	Automated	3/23/2017	Approved
Providers are only allowed to bill 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 rule identifies claims for patients who have been seen by the same	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	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 rule identifies claims for patients who have been seen by the same	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and	Automated	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services may not be billed for patients while admitted to a hospital setting. Services billed incorrectly will result in an overpayment and will be recouped.	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	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	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	Automated	3/23/2017	Approved
A new patient is one who has not received any professional services, [e.g., E/M service or other face-to-face service (e.g., surgical procedure)] from the physician or physician group practice (same physician specialty) within the previous 3 years. The subsequently billed new patient visit will be denied if another E/M procedure	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	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	Automated	3/23/2017	Approved
A new patient is one who has not received any professional services, [e.g., E/M service or other face-to-face service (e.g., surgical procedure)] from the physician or physician group practice (same physician specialty) within the previous 3 years. The subsequently billed new patient visit will be denied if another E/M procedure	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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, 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, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	4/26/2017	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 SNF's Medicare Part A	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	Automated	8/8/2017	Approved
Algorithm identifies all paid Ambulance claims billed with any HCPCS codes listed in Appendix D with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance transportation provided by outside suppliers to SNF residents is included in the SNF's Medicare Part A	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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,	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,	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	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	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	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 coordinate reimbursement from the inpatient facility. The edit will deny 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	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, Revisions	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	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, Revisions	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 denied.	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	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/AM 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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	Automated	8/7/2017	Approved
Shoulder arthroscopy procedures include a limited debridement (CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day.	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, Revisions	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.	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, Revisions	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 (ORF), Comprehensive Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	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 (ORF), Comprehensive Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	Automated	9/8/2017	Approved
The Nursing Facility services codes represent a "per day" service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service. Relevant CPT codes billed more than once per day will result in an overpayment.	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 3. 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information; 4. 42 Code of Federal Regulations §424.5(a)(6)- Sufficient Information	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 §424.5(a)(6)- Sufficient Information	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 claims billed with modifier TC and claim line for service codes with TC/PC	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	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 line billed with modifier TC and claim line for service codes with TC/PC	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond	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	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	Automated	9/8/2017	Approved
Inpatient hospital services furnished to a patient or 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 denied.	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. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1815(a)- Payment to Providers of Services; 2. Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 3. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 4. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer	Complex	9/8/2017	Approved
Inpatient hospital services furnished to a patient or 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 denied.	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. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1815(a)- Payment to Providers of Services; 2. Title XVIII of the Social Security Act (SSA), Section 1833(e)- Payment of Benefits; 3. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 4. Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request	Automated	10/5/2017	Approved
Outpatient service dates that fall totally within inpatient admission and discharge dates at the same or another provider or outpatient bill that overlaps an inpatient admission are considered exact duplicates and should be rejected.	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B, TOB: 12x, 13x	3 years prior to the Informational Letter date	2 - all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42 CFR §405.930- Failure to Respond to Additional Documentation Request	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 §405.930- Failure to Respond to Additional Documentation Request	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 condition,	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	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 services, 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	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	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	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	Complex	12/21/2017	Approved
Drugs and Biologicals are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that CPT/HCPCS long descriptor, and correspond to	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	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,	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,	Automated	1/9/2018	Approved
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Cardiac Pacemakers: Medical Necessity and Documentation Requirements	Outpatient Hospital (OP), Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations,	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, 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,	Complex	2/15/2018	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. Providers billing for more than one unit of cataract removal for the same eye, on the same claim line, will be denied. The New Issue indicates the findings bill denials regarding this issue.	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,	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 findings bill denials regarding this issue.	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,	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 the entire claim line.	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	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 the entire claim line.	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	Automated	3/14/2018	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services. Denied services will result in an	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 XVII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions,	Automated	3/13/2018	Approved
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	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory, Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII - Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions,	Automated	3/13/2018	Approved
Hospital outpatient observation care (initial, subsequent and/or discharge management) rendered on the same date as a hospital inpatient admission by the same physician is not separately payable. Medicare payment for the initial hospital inpatient admission is not separately payable.	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	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 inpatient admission is not separately payable.	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	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	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	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	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	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,	Automated	3/14/2018	Approved
Covered ancillary items and services are not payable if there is no approved Ambulatory Surgical Center (ASC) surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations,	Automated	3/14/2018	Approved
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	Automated	3/14/2018	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - Clinical Social Worker during Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and	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	Automated	4/4/2018	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The technical component (TC) of lab/pathology services furnished to patients in an inpatient or outpatient setting are not separately payable.	0090 - Laboratory/Pathology Technical Component for Inpatient or Outpatient Hospitals: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Laboratory; Independent Diagnostic Testing Facility (IDTF)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	4/4/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in a	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	Automated	5/8/2018	Approved
Duplicate claims are any claims paid across more than one claim number for the same Beneficiary, CPT/HCPCS code and service date by the same provider. Duplicate claims will be denied if billed with exact data and the contractor paid for services more than once. Denied duplicate claims will result in a	0091- Duplicate Claims: Professional Services	Part B Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional	Automated	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcuteaneous 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,	Complex	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcuteaneous placement of a device.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations,	Complex	5/8/2018	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be required for medic	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	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 required for medic	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	Complex	5/14/2018	Approved
Facet joint are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. Intraarticular blocks may provide	0095 - Facet Joint Interventions: Medical Necessity and Documentation Requirements	Inpatient Hospital (Part B), Outpatient Hospital, Outpatient Surgery	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	6/18/2018	Approved
Certain CPT codes for Part B professional services for the same beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care.	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	6/18/2018	Approved
Certain CPT codes for Part B professional services for the same beneficiary, same Date of Service, and Same Provider will be recovered as overpayments as they are not payable when performed on the same day a physician bills for critical care.	0098 - Critical Care Professional Services: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	6/18/2018	Approved
Payment for the Skilled Nursing Facility (SNF) services, listed in the SNF Consolidated Billing Table, Major Category I.F and V.A., provided to beneficiaries by the outpatient facility, in a Medicare covered Part A SNF stay, are included in a bundled prospective payment and are not separately payable. Payment for those	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,	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	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,	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	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,	Automated	6/20/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid	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,	Automated	6/20/2018	Approved
APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate	0101 - Ambulatory Payment Classification Coding Validation	Outpatient Hospital	3 years prior to ADR Letter date	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	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	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	7/26/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also paid. ASC providers paid for Add-On	0104 - Add-on Code Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	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	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	0104 - Add-on Code Paid without Primary Code and/or Denied Primary Code – Ambulatory Surgical Center	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	7/24/2018	Approved
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 hospice provider. Medicare should not be billed for either of the	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. Social Security Act (SSA), 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. SSA, Title XVIII, §1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 4. 42 CFR	Automated	8/14/2018	Approved
Physician services billed during an active hospice period should be paid by the hospice provider if services are related to the hospice beneficiary's terminal condition or if a physician is employed or paid under arrangement by the hospice provider. Medicare should not be billed for either of the	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. Social Security Act (SSA), 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. SSA, Title XVIII, §1861 (dd) of the Social Security Act, Hospice Care; Hospice Program; 4. 42 CFR	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	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	6 months 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,	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	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	6 months prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations,	Automated	9/11/2018	Approved

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 based on the MAC Underpayment	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefits; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1834 - Special Payment Rules for Particular Items and Services; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section	Complex	2/20/2019	Approved
Pulmonary rehabilitation is a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical Documentation will be reviewed to determine if pulmonary rehabilitation is medically reasonable and necessary.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital 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	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.	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA) §§1861 (s)(2)(CC) - Medical and Other Health	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 are in the SNF Consolidated Billing, Part A MAC Underpayment	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,	Automated	4/2/2019	Approved
Services provided by a freestanding non-hospital ASC (Ambulatory Surgery Center) are included under the SNF Consolidated Billing Provisions. Certain services are not payable because they are included in SNF Consolidated Billing. Codes are in the SNF Consolidated Billing, Part A MAC Underpayment	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,	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	Complex	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	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	4/2/2019	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	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	Automated	3/27/2019	Approved
When a more extensive magnetic resonance imaging is performed on the same site as a less extensive MRI, the less extensive MRI is bundled into the more extensive MRI. The less extensive MRI procedure code(s) will be recovered as an overpayment.	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	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.	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	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 90231-90233 will be assigned and 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 90231-90233 will be assigned.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner); exclude non-physician practitioner codes 50 (NP) and 67 (PA)	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	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 90231-90233 will be assigned.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner); exclude non-physician practitioner codes 50 (NP) and 67 (PA)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	4/22/2019	Approved
Mohs micrographic surgery is a two-step process in which 1) the tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. This review will verify that the physician who performs the	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	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	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	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	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 are billable under the MPFS.	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	Complex	4/24/2019	Approved
The Medicare Physician Fee Schedule (MPFS) is the primary method of payment for enrolled health care professionals. Documentation will be reviewed to determine if professional services that affecting MPFS payment meet Medicare coverage criteria and are billable under the MPFS.	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	4/24/2019	Approved
Ambulatory Surgical Center coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the CPT/HCPCS codes and associated modifiers by	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42	Complex	5/28/2019	Approved
Ambulatory Surgical Center coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate the CPT/HCPCS codes and associated modifiers by	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	3 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42	Complex	5/28/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary provides 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	0154 - Non-Emergency Ambulance Services-Advanced Life Support and Basic Life Support: Medical Necessity and Documentation	Ambulance Providers	3 years prior to ADR Letter date as well as state/date exclusions: 1. Exclude NJ, PA, SC, DE, DC, MD, NC, WV, VA	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	Complex	5/22/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary provides 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	0154 - Non-Emergency Ambulance Services-Advanced Life Support and Basic Life Support: Medical Necessity and Documentation	Ambulance Providers	3 years prior to ADR Letter date as well as state/date exclusions: 1. Exclude NJ, PA, SC, DE, DC, MD, NC, WV, VA	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and	Complex	5/22/2019	Approved
Medicare pays for non-emergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e. would endanger the beneficiary). The beneficiary provides a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical	0157 - Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC)	3 years prior to ADR Letter date	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	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 inpatient hospital department and to ambulatory surgical center 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 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 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 on any day, therefore the first 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 meet medical coverage criteria will result in a denial.	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	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 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 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 on any day, therefore the first 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 meet medical coverage criteria will result in a denial.	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. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Automated	7/15/2019	Approved
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 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 on any day, therefore the first 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 meet medical coverage criteria will result in a denial.	0158 - Outpatient Therapy Services During Home Health: Unbundling	Outpatient Hospital, Skilled Nursing Facility (SNF), Outpatient Hospital, Outpatient Rehabilitation Facility	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Automated	7/15/2019	Approved
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 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 on any day, therefore the first 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 meet medical coverage criteria will result in a denial.	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	Automated	6/19/2019	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 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 on any day, therefore the first 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 meet medical coverage criteria will result in a denial.	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	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 meet medical coverage criteria will result in a denial.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation	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	Complex	8/20/2019	Approved
Medical documentation will be reviewed to determine if the use of intravenous immune globulin for the treatment of Autoimmune Blistering Diseases (AMBDs) meets Medicare coverage criteria and is reasonable and necessary. Services that meet medical coverage criteria will result in a denial.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation	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	Complex	8/20/2019	Approved
Documentation will be reviewed to determine if correct billing, coding, and documentation guidelines for Therapeutic, Prophylactic, and Diagnostic Infusions were met.	0161 - Therapeutic, Prophylactic, and Diagnostic Infusions: Incorrect Coding and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	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	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 Infusions: Incorrect Coding and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	11/18/2019	Approved
All diagnostic tests, including Computed Tomography (CT) Coronary Angiography, must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's medical condition.	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	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 medical condition. Tests not ordered by the physician who is treating the	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	Complex	7/22/2019	Approved
Ambulance transports of a hospice patient, which are related to the terminal illness and occur after the effective date of election, are the responsibility of the hospice provider. Payment for the ambulance claim will be recouped if the above conditions are met.	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	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 conditions are met.	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	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/leg/eye/applicable multiple.	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	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/leg/eye/applicable multiple.	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.980- Reopening of Initial	Automated	9/24/2019	Approved
Under specific requirements, Medicare covers FDG (Fluorodeoxyglucose) Positron Emission Tomography (PET) scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be reviewed to determine if the use of 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 use of PET scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be	0165 - Positron Emission Tomography for Previously-Denied Facility Claims for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation	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	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 use of PET scans for the differential diagnosis of fronto-temporal dementia (FTD) and Alzheimer's disease (AD). Medical records will be	0165 - Positron Emission Tomography for Previously-Denied Facility Claims for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation	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	Complex	9/25/2019	Approved
When a procedure is performed, there are sometimes two claims submitted for the same code. The facility's claim for a procedure is submitted and the surgeon's claim for the procedure is also submitted. The documentation for this procedure is submitted with the CPT/HCPCS code billed. If the same procedure is performed	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsy and Right Heart Catheterization: Billed	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	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 submitted with the CPT/HCPCS code billed. If the same procedure is performed	0168 - Denial of the Professional Component for Previously-Denied Facility Claims for Medically Unnecessary Endomyocardial Biopsy and Right Heart Catheterization: Billed	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Automated	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 provided to a beneficiary	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 405.930- Failure to	Automated	11/27/2019	Approved
All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to and including the date of the beneficiary's admission are provided to a beneficiary	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Hospital	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Automated	11/27/2019	Approved
Documentation will be reviewed to determine if renal and peripheral angiography procedures meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and	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	Complex	11/19/2019	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if 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	Complex	11/19/2019	Approved
Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications. Medical records will be reviewed to determine if the 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	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	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	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	Complex	12/27/2019	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).	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	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).	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	Complex	1/22/2020	Approved
Claims for HCPCS code G0402-Initial Preventative Physical Examination (IPPE), may not be billed more than 12 months after the effective date of the beneficiary's first part B coverage, or more than once in a lifetime.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (s)(2)(FF)- Medical and other health services- personalized prevention plan services; 3. Social Security	Complex	1/23/2020	Approved
Claims for HCPCS code G0402-Initial Preventative Physical Examination (IPPE), may not be billed more than 12 months after the effective date of the beneficiary's first part B coverage, or more than once in a lifetime.	0176 - Annual Wellness Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1861 (s)(2)(FF)- Medical and other health services- personalized prevention plan services; 3. Social Security	Complex	1/23/2020	Approved
The focus of this issue is to target claims where a potential overpayment exists when the definition of the procedure code includes imaging and the imaging was billed separately and paid.	0179 - Procedures that Include Imaging: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	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	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.	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,	Automated	8/3/2020	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 processed with the 25% reduction.	0182 - Reduction of Technical Component Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations,	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 Services (SCT). SCT transportation has been defined as 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 Services (SCT).	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	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 Services (SCT).	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	Complex	8/3/2020	Approved
For purposes of coverage under Medicare, total hip arthroplasty (THA) also referred to as joint replacement, has 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 are	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)-	Complex	8/3/2020	Approved
For purposes of coverage under Medicare, total hip arthroplasty (THA), also referred to as joint replacement, has 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 are	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)-	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).	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory 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)-	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).	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory 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)-	Complex	8/3/2020	Approved
This review will determine if a duplex scan of the extracranial arteries was reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Complex	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	Complex	8/3/2020	Approved
Medical documentation will be reviewed to determine if the use of nerve conduction studies meets Medicare coverage criteria and is reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	3 years prior to ADR Letter date	2 – all applicable states	1. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 Code of Federal Regulations (CFR) §410.32- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests:	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:	Complex	9/25/2020	Approved
Documentation will be reviewed to determine if the Skilled Nursing Facility stay meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0190 - Skilled Nursing Facility with Patient-Driven Payment Model: Medical Necessity and Documentation Requirements	Skilled Nursing Facility (SNF)	3 years prior to ADR Letter date	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	Complex	7/20/2022	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	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as 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 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	7/20/2022	Approved
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	3 years prior to ADR Letter date	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	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.	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 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	9/24/2020	Approved
A ventricular assist device (VAD) is surgically attached to one or both intact ventricles and is used to assist or augment the ability of a damaged or weakened native heart to pump blood. Improvement in the performance of the native heart may allow the device to be removed. The documentation will be reviewed to	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	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	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	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	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	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	Complex	10/1/2020	Approved
Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that	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	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 to ensure Medicare coverage criteria for an	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	Complex	10/23/2020	Approved
The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed to ensure Medicare coverage criteria for an	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	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 receive electrical impulses that regulate abnormal impulses within	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	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 receive electrical impulses that regulate abnormal impulses within	0196 - Deep Brain Stimulation- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	11/18/2020	Approved
Deep brain stimulation (DBS) is an established treatment for people with movement disorders, such as essential tremor, Parkinson's disease and dystonia. DBS involves implanting electrodes within certain areas of the brain; these electrodes receive electrical impulses that regulate abnormal impulses within	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	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 receive electrical impulses that regulate abnormal impulses within	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	11/18/2020	Approved
The purpose of this review is to ensure Medicare coverage criteria for an 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	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 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Complex	2/4/2021	Approved
The purpose of this review is to ensure Medicare coverage criteria for an 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	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 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	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	Automated	2/4/2021	Approved
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay. A denial of services will result in an overpayment.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR 405.929- Post-Payment Review; 4. 42 CFR 405.930- Failure to	Automated	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 procedure, separately paid codes will	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	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 procedure, separately paid codes will	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	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	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	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	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	Complex	3/11/2021	Approved
Effective for services performed on or after March 16, 2018, the Centers for Medicare & Medicaid Services (CMS) has determined that Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally when performed in a Clinical Laboratory Improvement	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	3 years prior to ADR Letter date	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	Complex	5/29/2021	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	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 §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request; 5. 42	Complex	5/29/2021	Approved
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	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	Complex	5/29/2021	Approved
Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) is covered only in clinical situations in which PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal location to perform an invasive procedure. PET would also be considered	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Hospital Outpatient, Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII - Health Insurance for the Aged and Disabled, Section 1833(e) - Payment of Benefit; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	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	0207 - Spinal Cord Stimulation: 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 Benefit; 3. 42 CFR §405.929 – Post-payment Review; 4. 42 CFR §405.930- Failure to	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	0207 - Spinal Cord Stimulation: 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 Benefit; 3. 42 CFR §405.929 – Post-payment Review; 4. 42 CFR §405.930- Failure to	Complex	5/29/2021	Approved
Hypoglossal nerve stimulation (HNS) is reasonable and necessary for the treatment of moderate to severe obstructive sleep apnea (OSA) when coverage criteria are met. Documentation will be reviewed to determine if HNS meets	0210 - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	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	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	0210 - Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioners)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. SSA, Title XVIII- Health Insurance for the Aged and Disabled, §1833(e)- Payment of Benefits; 3. 42 CFR §405.980- Reopening of Initial Determinations, Redeterminations, Reconsiderations, Decisions, and	Complex	6/29/2022	Approved
Per the 2019 and 2020 AMA CPT manuals, do not report CPT codes 99358 and/or 99359 during the same calendar month as CPT codes 99484, 99487, 99489, 99490, 99491, 99492, 99493, 99494.	0211 - Prolonged Service Codes: Unbundling	Professional Services (Physician/Non-Physician Practitioners)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer; 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits; 3. 42 CFR §405.929- Post-Payment Review; 4. 42 CFR §405.930- Failure to	Automated	1/26/2023	Approved
Documentation will be reviewed to determine whether Transurethral waterjet ablation services met Medicare coverage criteria and were reasonable and necessary.	0214 - Transurethral Waterjet Ablation of the Prostate for Benign Prostatic Hyperplasia (BPH) with Lower Urinary Tract Symptoms (LUTS): Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)	3 years prior to ADR Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3. 42 CFR §405.929- Post-Payment Review 4. 42 CFR §405.930- Failure to Respond to Additional Documentation Request	Complex	4/26/2023	Approved
Physicians: Inpatient dialysis services furnished to ESRD, or acute dialysis patients are processed using inpatient dialysis services procedure codes 90935, 90937, 90945, and 90947. A/B MACs make payment based on these ESRD codes, only if the place of service on the claim is inpatient hospital (21). This is because all	0213 - Inpatient Dialysis Service Codes Billed for Outpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Automated	4/26/2023	Approved