Cotiviti Approved Issues List as of April 25, 2018

All physician/NPP specialties	32
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Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Clinical Validation is not permitted.	0001 - Complex Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	1) CMS Program Integrity Manual Ch. 6.5.3 A-C DRG Validation Review; 2) CMS QIO Manual Section 4130; 3) ICD-9 & 10 CM Coding Manual; 4) ICD-9 & 10 CM Addendums; 5) ICD-9 & 10 CM Official Guidelines for Coding and Reporting, and Addendums; 6) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 7) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017 0:00	Approved
MS-DRG Coding requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate MS-DRGs for principal and secondary diagnosis and procedures affecting or potentially affecting the MS-DRG assignment. Clinical Validation is not permitted.	0001 - Complex Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	1) CMS Program Integrity Manual Ch. 6.5.3 A-C DRG Validation Review; 2) CMS QIO Manual Section 4130; 3) ICD-9 & 10 CM Coding Manual; 4) ICD-9 & 10 CM Addendums; 5) ICD-9 & 10 CM Official Guidelines for Coding and Reporting, and Addendums; 6) ICD-10 Procedural Coding System (PCS) Coding Manual, Official Guidelines for Coding and Reporting, and Addendums; 7) Coding Clinic for ICD-10-CM and ICD-10-PCS	Complex	1/23/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0002 - Complex Cataract Removal	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states; excluding WPS	CMS NCD 10.1, Effective 8/31/1992; CMS NCD 80.10; CMS NCD 80.12, Effective 5/19/1997; NGS LCD L33558, effective date 10/1/2015 Revision 11/1/2016; Palmetto LCD L34413, Effective Date 10/01/2015; Revision 03/14/2016, Revision 05/19/2016, Revision 10/01/2016, Revision 05/11/2017, Revision 06/11/2017, Revision 07/10/2017; Palmetto Article A53047, Effective Date 10/01/2015; Novitas LCD L35091, Effective Date 10/01/2015, Revision Effective 11/01/2016; First Coast LCD L33808, Effective Date 10/01/2015; and Cahaba LCD L34287, Effective Date 10/01/2015 PART B ONLY	Complex	2/12/2017 0:00	Approved
Documentation will be reviewed to determine if Cataract Surgery meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0002 - Complex Cataract Removal	Ambulatory Surgery Center (ASC), Outpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	CMS NCD 10.1, Effective 8/31/1992; CMS NCD 80.10; CMS NCD 80.12, Effective 5/19/1997; NGS LCD L33558, effective date 10/1/2015 Revision 11/1/2016; Palmetto LCD L34413, Effective Date 10/01/2015; Revision 03/14/2016, Revision 05/19/2016, Revision 10/01/2016, Revision 05/11/2017, Revision 06/11/2017, Revision 07/10/2017; Palmetto Article A53047, Effective Date 10/01/2015; Novitas LCD L35091, Effective Date 10/01/2015, Revision Effective 11/01/2016; First Coast LCD L33808, Effective Date 10/01/2015; and Cahaba LCD L34287, Effective Date 10/01/2015 PART B ONLY	Complex	2/12/2017 0:00	Approved
Documentation will be reviewed to determine if Sacral Neurostimulation meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0003 - Complex Medical Necessity Sacral Neurostimulation	Inpatient, Outpatient, ASC, Physician	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); 42 CFR §405.980(b) and (c); 42 CFR §405.986; CMS IOM 100-3, National Coverage Determination 230.18, Effective 1/1/2002; CMS IOM 100-04 Medicare Claims Processing, Chapter 32, Section 40, Effective 1/1/2002; First Coast LCD L36296, Sacral Neuromodulation, Effective 10/1/2015; and Novitas LCD L35449, Sacral Nerve Stimulation, Effective 10/1/2015; Novitas LCD L34707, Sacral Nerve Stimulation, Effective 7/24/14 – 9/30/2015	Complex	1/23/2017 0:00	Approved
Documentation will be reviewed to determine if Sacral Neurostimulation meets Medicare coverage criteria, meets applicable coding guidelines, and/or is medically reasonable and necessary.	0003 - Complex Medical Necessity Sacral Neurostimulation	Inpatient, Outpatient, ASC, Physician	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); 42 CFR §405.980(b) and (c); 42 CFR §405.986; CMS IOM 100-3, National Coverage Determination 230.18, Effective 1/1/2002; CMS IOM 100-04 Medicare Claims Processing, Chapter 32, Section 40, Effective 1/1/2002; First Coast LCD L36296, Sacral Neuromodulation, Effective 10/1/2015; and Novitas LCD L35449, Sacral Nerve Stimulation, Effective 10/1/2015; Novitas LCD L34707, Sacral Nerve Stimulation, Effective 7/24/14 – 9/30/2015	Complex	1/23/2017 0:00	Approved
Medical Necessity and Documentation Review	0004 - SNF Review: Documentation and Medical Necessity	SNF	3 years prior to the ADR Letter date	2 - all applicable states	42 CFR 409.30-409.36; 42 CFR 424.20; 42 CFR 483.20; IOM 100-01, Chapter 4, §40.4-40.5; IOM 100-08, Chapter 6, §§6.1 and 6.3; IOM 100-02, Chapter 8, §20-40; IOM 100-02, Chapter 15, §220.1.3	Complex	6/13/2017 0:00	Approved
Medical Necessity and Documentation Review	0004 - SNF Review: Documentation and Medical Necessity	SNF	3 years prior to the ADR Letter date	3 - all applicable states	42 CFR 409.30-409.36; 42 CFR 424.20; 42 CFR 483.20; IOM 100-01, Chapter 4, §40.4-40.5; IOM 100-08, Chapter 6, §§6.1 and 6.3; IOM 100-02, Chapter 8, §20-40; IOM 100-02, Chapter 15, §220.1.3	Complex	6/13/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary.	0008 - Complex Medical Necessity Bariatric Surgery	Outpatient Hospital, Inpatient Hospital	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA): Section 1862(a)(1)(A); CMS Publication 100-03.National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; First Coast LCD L33411: Effective 10/1/2015; Revised 10/1/2016; LCD L29317: Effective 2/2/2009; Revised 2/19/2015; Retired 9/30/2015; LCD L33019: Effective 1/29/2013; Revised 2/19/2015; Retired 9/30/2015; NGS LCA A52447: Effective 10/1/2015; A51967: Effective 10/1/2012; Revised 9/1/2014; Retired 9/30/2015; Novitas LCD L35022: Effective 10/1/2015; Revised 1/1/2017; L32619: Effective 8/13/2012; Revised 10/2/2014; Retired 9/30/2015; L34495: Effective 12/5/2013; Revised 10/3/2014; Retired 9/30/2015; Palmetto GBA LCD L34576: Effective 10/1/2015; Revised 7/1/2017; LCD L32975: Effective 3/11/2013; Revised 8/27/2015; Retired 9/30/2015; and WPS LCA A54923: Effective 3/1/2016; Revised 3/1/2017	Complex	1/23/2017 0:00	Approved
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI > 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity. Claims reporting surgical services for beneficiaries that do not meet all the Medicare coverage guidelines will be denied as not medically necessary.	0008 - Complex Medical Necessity Bariatric Surgery	Outpatient Hospital, Inpatient Hospital	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA): Section 1862(a)(1)(A); CMS Publication 100-03.National Coverage Determinations Manual, Chapter 1, Part 2, Section 100.1- Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity, Effective 9/24/2013; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 150- Billing Requirements for Bariatric Surgery for Morbid Obesity; First Coast LCD L33411: Effective 10/1/2015; Revised 10/1/2016; LCD L29317: Effective 2/2/2009; Revised 2/19/2015; Retired 9/30/2015; LCD L33019: Effective 1/29/2013; Revised 2/19/2015; Retired 9/30/2015; NGS LCA A52447: Effective 10/1/2015; A51967: Effective 10/1/2012; Revised 9/1/2014; Retired 9/30/2015; Novitas LCD L35022: Effective 10/1/2015; Revised 1/1/2017; L32619: Effective 8/13/2012; Revised 10/2/2014; Retired 9/30/2015; L34495: Effective 12/5/2013; Revised 10/3/2014; Retired 9/30/2015; Palmetto GBA LCD L34576: Effective 10/1/2015; Revised 7/1/2017; LCD L32975: Effective 3/11/2013; Revised 8/27/2015; Retired 9/30/2015; and WPS LCA A54923: Effective 3/1/2016; Revised 3/1/2017	Complex	1/23/2017 0:00	Approved
Cataract removal can only occur once per eye during a lifetime. This issue identifies overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye in the look back period.	0009 - Automated Cataract Surgery Once in a Lifetime	Outpatient Hospital, ASC	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); CMS Pub 100-08, Ch. 3, §3.6; National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	1/23/2017 0:00	Approved
Cataract removal can only occur once per eye during a lifetime. This issue identifies overpayments associated to outpatient hospital providers billing more than one unit of cataract removal for the same eye in the look back period.	0009 - Automated Cataract Surgery Once in a Lifetime	Outpatient Hospital, ASC	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); CMS Pub 100-08, Ch. 3, §3.6; National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	1/23/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Documentation will be reviewed to determine if Cardiac PET Scans meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0010 - Complex Medical Necessity Cardiac PET Scans	Outpatient Hospital, Physician	3 years prior to the ADR Letter date	3 - Florida, PR and VI ONLY	CMS NCD 220.6.1; CMS NCD 220.6.8; CMS IOM 100-04, Chapter 13, §60; First Coast LCD L36209, (FL, PR, VI) (A/B), Effective date 10/1/2015; First Coast LCD L35933, (FL, PR, VI) (A/B), Effective date 6/29/2015, Retired 9/30/2015; First Coast LCD L33728, (FL, PR, VI) (A/B), Effective date 6/29/2015, Retired 9/30/2015; First Coast LCD L29455, (PR, VI) (B), Effective date 3/2/2009, Retired 6/29/2015; First Coast LCD L28954, (PR, VI) (A), Effective date 3/2/2009, Retired 6/29/2015; First Coast LCD L28933, (FL) (A), Effective date 2/16/2009, Retired 6/29/2015; First Coast LCD L29231, (FL) (B) Effective date 2/2/2009, Retired 6/29/2015; Annual American Medical Association: CPT Manual, Coding Guidelines; Annual ICD-9-CM Manual, Coding Guidelines; Annual HCPCS Manual, Coding Guidelines	Complex	1/24/2017 0:00	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate billing of Home Health E&M codes during Inpatient	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	1) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30.6.14; 2) CPT Manual 2013-present	Automated	1/29/2017 0:00	Approved
Home Services Billed for Hospital Inpatients - Home Services CPT Codes may not be used for billing services provided in settings other than in the private residence of a beneficiary.	0011 - Inappropriate billing of Home Health E&M codes during Inpatient	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	1) Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30.6.14; 2) CPT Manual 2013-present	Automated	1/29/2017 0:00	Approved
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay.Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Automated Inpatient Psych Billed without Source of Admission Equal to D	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	2 - all applicable states	Claims Processing Manual (100-04), Chapter 3, Section 190.6.4; Claims Processing Manual (100-04), Chapter 3, Section 190.6.4.1; 4. Claims Processing Manual (100-04), Chapter 3, Section 190.10.1	Automated	2/27/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay.Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.	0022 - Automated Inpatient Psych Billed without Source of Admission Equal to D	Inpatient Hospital, Inpatient Psychiatric Facility	3 years prior to the Informational Letter date	3 - all applicable states	Claims Processing Manual (100-04), Chapter 3, Section 190.6.4; Claims Processing Manual (100-04), Chapter 3, Section 190.6.4.1; 4. Claims Processing Manual (100-04), Chapter 3, Section 190.10.1	Automated	2/27/2017 0:00	Approved
To identify claims where modifier -59 has been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together.	0027 - Improper payments for Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Physician	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); NCCI Manuals 2015, 2016, and 2017 Chapter 11; CPT Manual	Complex	4/3/2017 0:00	Approved
To identify claims where modifier -59 has been inappropriately appended when Endomyocardial Biopsies and Right Heart Catheterizations are billed together.	0027 - Improper payments for Endomyocardial Biopsies and Right Heart Catheterizations that were Not Distinct Services	Outpatient Hospital, Physician	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); NCCI Manuals 2015, 2016, and 2017 Chapter 11; CPT Manual	Complex	4/3/2017 0:00	Approved
HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service [pps], initial visit) is a one time" allowed Medicare benefit per beneficiary"	0028 - Annual Wellness Visits (AWV)	Physician/Non-physician Practitioner	3 years prior to the Informational Letter date	2 - all applicable states	1. Title XVIII of the Social Security Act, §§1861(s)(2)(FF) and 1861(hhh);2. CMS Pub. 100-02, Chapter 15, Section 280.5 (Annual Wellness Visit [AWV] Providing Personalized Prevention Plan Services [PPPS]) (Effective 5/10/2013); 3. CMS Pub. 100-04, Chapter 12, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV] (Effective 1/27/2014); CMS Pub. 100-04,Chapter 18, Sections 140 - 140.8 (Effective 1/1/2011)	Automated	4/26/2017 0:00	Approved
HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service [pps], initial visit) is a one time" allowed Medicare benefit per beneficiary"	0028 - Annual Wellness Visits (AWV)	Physician/Non-physician Practitioner	3 years prior to the Informational Letter date	3 - all applicable states	1. Title XVIII of the Social Security Act, §§1861(s)(2)(FF) and 1861(hhh);2. CMS Pub. 100-02, Chapter 15, Section 280.5 (Annual Wellness Visit [AWV] Providing Personalized Prevention Plan Services [PPPS]) (Effective 5/10/2013); 3. CMS Pub. 100-04, Chapter 12, Section 30.6.1.1 Initial Preventive Physical Examination [IPPE] and Annual Wellness Visit [AWV] (Effective 1/27/2014); CMS Pub. 100-04,Chapter 18, Sections 140 - 140.8 (Effective 1/1/2011)	Automated	4/26/2017 0:00	Approved

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

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 10 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 010 include only E&M services on the day of the procedure and up to 10 post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0033 - E&M Codes billed within a Procedure Code with a 10 Day Global Period (other minor procedures)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833[42 U.S.C. 1395l](e); Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §40.3, Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10, 01-01-2012-ASC X12; Implementation: 08-25-2014-ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum–MPFSDB Record Layouts (Rev. 3693, Issued: 01-13-17, Effective: 01-01-17-Implementation: 01-03-17)	Automated	12/12/2017	Approved
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 90 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 090 include only E&M services on the day before the procedure, the day of the procedure and up to 90 days post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0034 - E&M Codes billed within a Procedure Code with a 90 Day Global Period (major surgeries)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 – all applicable states	Social Security Act, Section 1833[42 U.S.C. 1395l](e); Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §40.3, Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10, 01-01-2012-ASC X12; Implementation: 08-25-2014-ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum–MPFSDB Record Layouts (Rev. 3693, Issued: 01-13-17, Effective: 01-01-17-Implementation: 01-03-17)	Automated	12/12/2017	Approved
This query identifies E&M Services that are incorrectly billed within the codes that have a Global Days designation of 90 days. Under the Medicare Physician Fee Physician (MPFS) rules, most surgical procedures include pre-op and post-op E&M services. These E&M services are referred to as 'Global Days'. Procedures with MPFS global days of 090 include only E&M services on the day before the procedure, the day of the procedure and up to 90 days post-op days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (unrelated E&M Service By Same Physician During Post-op Period), 25 (Significant E&M Service By Same Physician on Date of Global Procedure) and 57 (Decision For Surgery Made within Global Surgical Period) on the E&M service.	0034 - E&M Codes billed within a Procedure Code with a 90 Day Global Period (major surgeries)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 – all applicable states	Social Security Act, Section 1833[42 U.S.C. 1395l](e); Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §40.3, Claims Review for Global Surgeries (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10, 01-01-2012-ASC X12; Implementation: 08-25-2014-ASC X12; Upon Implementation of ICD-10), Chapter 23, Addendum–MPFSDB Record Layouts (Rev. 3693, Issued: 01-13-17, Effective: 01-01-17-Implementation: 01-03-17)	Automated	12/12/2017	Approved
Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines.	0036 - Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed	Physician, Outpatient Hospital, Professional Services	3 years prior to the ADR Letter date	2 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40; CDC: Questions about Multi-dose vials; Package label (manufacturer website): Herceptin	Complex	2/27/2017 0:00	Approved
Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines.	0036 - Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed	Physician, Outpatient Hospital, Professional Services	3 years prior to the ADR Letter date	3 - all applicable states	Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual, 100-04, Chapter 17, Section 40; CDC: Questions about Multi-dose vials; Package label (manufacturer website): Herceptin	Complex	2/27/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Excessive Units of Hospital Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); CMS Pub. 100-04, Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 (Physicians/Non-physician Practitioner's), § 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016).	Automated	3/23/2017 0:00	Approved
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.	0037 - Excessive Units of Hospital Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); CMS Pub. 100-04,Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12 (Physicians/Non-physician Practitioner's), § 30.6.7.A (Definition of New Patient for Selection of E/M Visit Code) (Effective 1/1/2016).	Automated	3/23/2017 0:00	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.	0038 - Visits to Patients in Swing Beds	Physician, Professional Services	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); CMS Pub. 100-04, Medicare Claims Processing Manual: Chapter 12, §§30.6.9-30.6.9.1 and §30.6.9.2; AMA Current Procedure Terminology Manual	Automated	3/23/2017 0:00	Approved
If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.	0038 - Visits to Patients in Swing Beds	Physician, Professional Services	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e); 42 Code of Federal Regulations §424.5(a)(6); CMS Pub. 100-04, Medicare Claims Processing Manual: Chapter 12, §§30.6.9-30.6.9.1 and §30.6.9.2; AMA Current Procedure Terminology Manual	Automated	3/23/2017 0:00	Approved
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Not a New Patient	Physician, Professional Services	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.7(A)	Automated	3/23/2017 0:00	Approved
Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.	0039 - Not a New Patient	Physician, Professional Services	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.7(A)	Automated	3/23/2017 0:00	Approved
Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.	0040 - Hospital Discharge Day Management Service	Physician, Professional Services	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.9.2	Automated	3/23/2017 0:00	Approved
Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.	0040 - Hospital Discharge Day Management Service	Physician, Professional Services	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.9.2	Automated	3/23/2017 0:00	Approved
If evaluation and management service are being rendered to patients admitted to an inpatient hospital setting, then CPT Codes 99221-99223, 99231-99233 and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for evaluation and management service provided in the physician's office, in an outpatient or other ambulatory facility	0042 - Office Visits Billed for Hospital Inpatients	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §§30.6.9.1, 30.6 and 30.6.10	Automated	3/23/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
If evaluation and management service are being rendered to patients admitted to an inpatient hospital setting, then CPT Codes 99221-99223, 99231-99233 and 99238-99239 are to be used. CPT codes 99201-99215 are to be used for evaluation and management service provided in the physician's office, in an outpatient or other ambulatory facility	0042 - Office Visits Billed for Hospital Inpatients	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §§30.6.9.1, 30.6 and 30.6.10	Automated	3/23/2017 0:00	Approved
Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.	0043 - New Patient Visits	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	1. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §§30.6.7.A, 30.6.1.1 and 30.6.9; 2. AMA CPTÂ© Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017 0:00	Approved
Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.	0043 - New Patient Visits	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	1. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §§30.6.7.A, 30.6.1.1 and 30.6.9; 2. AMA CPTÂ© Manual, Evaluation and Management Services Guidelines (1999 through present)	Automated	3/23/2017 0:00	Approved
Potential incorrect billing occurred when Panretinal (Scatter) Laser Photocoagulation (CPT code 67228) is paid more than once, per eye, within the global surgery period	0047 - Panretinal (Scatter) Laser Photocoagulation - Excess Frequency	Outpatient Hospital (OPH), Physician/Non-physician	3 years prior to the Informational Letter date	2 - NGS states only: IL, MN, WI	Title XVIII of the Social Security Act (SSA): §1833(e); Title XVIII of the Social Security Act (SSA): §1862(a)(1)(A); CMS Publication 100-08, Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), §3.5.1 (Re-opening Claims) and §3.6 (Determinations Made During Review); National Government Services (NGS) LCD L28497 (Retired 9/30/2015); NGS LCD L33628 (Revised 10/1/2016)	Automated	4/26/2017 0:00	Approved
Ambulance claims for SNF to SNF transfers (modifier NN) are not separately payable under Part B. The SNF discharging the Beneficiary to another SNF is financially responsible for the transportation fees. Ambulance providers should seek payment from the transferring SNF.	0049 - Ambulance SNF to SNF Transfer	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	Medicare Claims Processing Manual: Publication 100-04; Chapter 6, §20.3.1, and Chapter 15, § 30.2.2; American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; Medicare Benefit Policy Manual: Publication 100-02; Chapter 10, §10.3.3	Automated	8/8/2017 0:00	Approved
Ambulance claims for SNF to SNF transfers (modifier NN) are not separately payable under Part B. The SNF discharging the Beneficiary to another SNF is financially responsible for the transportation fees. Ambulance providers should seek payment from the transferring SNF.	0049 - Ambulance SNF to SNF Transfer	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	Medicare Claims Processing Manual: Publication 100-04; Chapter 6, §20.3.1, and Chapter 15, § 30.2.2; American Medical Association (AMA), Professional HCPCS Level II Manual 2014 to current; Medicare Benefit Policy Manual: Publication 100-02; Chapter 10, §10.3.3	Automated	8/8/2017 0:00	Approved
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or denied Primary Code	Physician, Professional Services/Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D; 3. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8; 5. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013)	Automated	4/26/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.	0050 - Add-on Codes Paid without Primary Code and/or denied Primary Code	Physician, Professional Services/Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	1. Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, § 30 D; 3. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 01, § 70; 4. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 16, § 40.8; 5. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 29, § 240 (revised 7/23/2013)	Automated	4/26/2017 0:00	Approved
When providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or profession (modifier 26) components for the same service.	0051 - Automated Global vs. TC/PC Split Reimbursements	Outpatient Hospital, Physician/NPP, Lab/Ambulance	3 years prior to the Informational Letter date	2 - all applicable states	1. Title XVIII of the Social Security Act (SSA), §1833(e); 2. Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; 3. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1(General Billing Requirements), §120 (Detection of Duplicate Claims); 4. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 5. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 13 (Radiology Services and Other Diagnostic Procedures), §20.1 (Professional Component [PC]), 20.2 (Technical Component [TC]), and 20.2.3 (Services Furnished in Leased Departments); 6. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients)	Automated	4/26/2017 0:00	Approved
When providers are reimbursed for global procedures and then receive additional reimbursement for technical (modifier TC) and/or profession (modifier 26) components for the same service.	0051 - Automated Global vs. TC/PC Split Reimbursements	Outpatient Hospital, Physician/NPP, Lab/Ambulance	3 years prior to the Informational Letter date	3 - all applicable states	1. Title XVIII of the Social Security Act (SSA), §1833(e); 2. Medicare Fee-for-Service Payment/Physician Fee Schedule PFS Relative Value Files; 3. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1(General Billing Requirements), §120 (Detection of Duplicate Claims); 4. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners), §20.2 (Relative Value Units); 5. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 13 (Radiology Services and Other Diagnostic Procedures), §20.1 (Professional Component [PC]), 20.2 (Technical Component [TC]), and 20.2.3 (Services Furnished in Leased Departments); 6. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), §80.2.1 (Technical Component [TC] of Physician Pathology Services to Hospital Patients)	Automated	4/26/2017 0:00	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility.	0054 - Ambulance during Inpatient Hospital Stay	Ambulance Providers	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: Publication 100-04, Chapter 3, §10.5; Medicare Claims Processing Manual: Publication 100-04, Chapter 15, §30.1.4	Automated	6/20/2017 0:00	Approved
Ambulance services during an Inpatient stay are included in the facility's PPS payment and are not separately payable under Part B, excluding the date of admission, date of discharge and any leave of absence days. Ambulance providers are expected to seek reimbursement from the inpatient facility.	0054 - Ambulance during Inpatient Hospital Stay	Ambulance Providers	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); Medicare Claims Processing Manual: Publication 100-04, Chapter 3, §10.5; Medicare Claims Processing Manual: Publication 100-04, Chapter 15, §30.1.4	Automated	6/20/2017 0:00	Approved
When evaluation and management (E/M) services are provided to patients in a Skilled Nursing Facility (SNF), CPT codes (99306, 99309, 99310) should be reported. It is inappropriate to report hospital inpatient care codes (99223, 99232, 99233) for SNF E/M services.	0056 - Evaluation and Management (E/M) Coding in Skilled Nursing Facilities	Physician/Non-physician Practitioner (NPP)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), §1833(e); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §30.6.13; AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
When evaluation and management (E/M) services are provided to patients in a Skilled Nursing Facility (SNF), CPT codes (99306, 99309, 99310) should be reported. It is inappropriate to report hospital inpatient care codes (99223, 99232, 99233) for SNF E/M services.	0056 - Evaluation and Management (E/M) Coding in Skilled Nursing Facilities	Physician/Non-physician Practitioner (NPP)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), §1833(e); CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, §30.6.13; AMA CPT Manual, Evaluation and Management section, Nursing Facility Services Guidelines	Automated	8/7/2017 0:00	Approved
Shoulder arthroscopy procedures include a limited debridement (e.g., CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter.	0057 - Arthroscopic Limited Shoulder Debridement	Outpatient Hospital, ASC, Physician/Non-Physician	3 years prior to the ADR Letter date	2 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, The Medicare Benefit Policy Manual, Chapter 16 §20; National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy - Effective January 1, 2014- January 1, 2017	Complex	9/8/2017 0:00	Approved
Shoulder arthroscopy procedures include a limited debridement (e.g., CPT code 29822). Code 29822, is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder for the same day for the same beneficiary at the same encounter.	0057 - Arthroscopic Limited Shoulder Debridement	Outpatient Hospital, ASC, Physician/Non-Physician	3 years prior to the ADR Letter date	3 - all applicable states	Title XVIII of the Social Security Act (SSA), Section 1833(e) and 1862(a)(1)(A); 42 Code of Federal Regulations §§411.15(k)(1), 424.5(a)(6); Internet Only Manual, The Medicare Benefit Policy Manual, Chapter 16 §20; National Correct Coding Initiative Policy Manual, Chapter 4, E, Arthroscopy • Effective January 1, 2014- January 1, 2017	Complex	9/8/2017 0:00	Approved
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider should enter a 1 in the units bill column per date of service.	0060 - Excessive Units - Untimed Therapy	OPH, OP Non-Hospital, SNF, ORF, CORF, Physician	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); CMS Pub 100-04, Ch. 5, § 20.2; American Medical Association (AMA), Current Procedure Terminology 2014 to current; Medicare Benefit Policy Manual: Chapter 5, Sections 10, 20, 30, 40 and 100; Medicare Benefit Policy Manual: Chapter 15, Sections 220 and 230; CMS Pub 100-04 CR 9698 December 1, 2016 (Transmittal 3670)	Automated	9/8/2017 0:00	Approved
When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider should enter a 1 in the units bill column per date of service.	0060 - Excessive Units - Untimed Therapy	OPH, OP Non-Hospital, SNF, ORF, CORF, Physician	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); CMS Pub 100-04, Ch. 5, § 20.2; American Medical Association (AMA), Current Procedure Terminology 2014 to current; Medicare Benefit Policy Manual: Chapter 5, Sections 10, 20, 30, 40 and 100; Medicare Benefit Policy Manual: Chapter 15, Sections 220 and 230; CMS Pub 100-04 CR 9698 December 1, 2016 (Transmittal 3670)	Automated	9/8/2017 0:00	Approved
The Nursing Facility Services codes represent a "per day" service. As such, these codes may only be reported once per day, per beneficiary, provider and date of service.	0061 - Excessive Units of Nursing Facility Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.13 (B); American Medical Association (AMA) Current Procedure Terminology 2014 to current	Automated	9/8/2017 0:00	Approved
The Nursing Facility Services codes represent a "per day" service. As such, these codes may only be reported once per day, per beneficiary, provider and date of service.	0061 - Excessive Units of Nursing Facility Services	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a) (1) (A); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.13 (B); American Medical Association (AMA) Current Procedure Terminology 2014 to current	Automated	9/8/2017 0:00	Approved
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator 1" and/or 3 for TC component only."	0062 - TC of Radiology Inpatient - FULL	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	2 - all applicable states	Medicare Claims Processing Manual 100-04; Chapter 13, § 20.2.1; Change Request 5675; Medicare Claims Processing Manual 100-04; Chapter 26, § 10.7 - Type of Service	Automated	9/8/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Carriers may not pay for the technical component (TC) of radiology services furnished to patients in hospital settings. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator 1" and/or 3 for TC component only."	0062 - TC of Radiology Inpatient - FULL	Radiologists/Part B providers doing radiology service	3 years prior to the Informational Letter date	3 - all applicable states	Medicare Claims Processing Manual 100-04; Chapter 13, § 20.2.1; Change Request 5675; Medicare Claims Processing Manual 100-04; Chapter 26, § 10.7 - Type of Service	Automated	9/8/2017 0:00	Approved
CPT Code 99291 is used to report the first 30 - 74 minutes of Critical Care on a given calendar date of service. It should only be used once per calendar date per beneficiary by the same physician or physician group of the same specialty.	0063 - Excessive Units of Initial Critical Care	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.12 Sections (F), (G) and (I)	Automated	9/8/2017 0:00	Approved
CPT Code 99291 is used to report the first 30 - 74 minutes of Critical Care on a given calendar date of service. It should only be used once per calendar date per beneficiary by the same physician or physician group of the same specialty.	0063 - Excessive Units of Initial Critical Care	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.12 Sections (F), (G) and (I)	Automated	9/8/2017 0:00	Approved
Duplicate claim or line date of service items are those where the same service is rendered and paid multiple times on the same date of service for the same beneficiary	0064 - Facility Duplicate Claims	IP, OP, SNF, OP Clinics, ORF, CORF	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04, Chapter 1, §120.2 (A); Medicare Financial Management Manual: Publication 100-06, Chapter 3, §10.2	Automated	9/8/2017 0:00	Approved
Duplicate claim or line date of service items are those where the same service is rendered and paid multiple times on the same date of service for the same beneficiary.	0064 - Facility Duplicate Claims	IP, OP, SNF, OP Clinics, ORF, CORF	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04, Chapter 1, §120.2 (A); Medicare Financial Management Manual: Publication 100-06, Chapter 3, §10.2	Automated	9/8/2017 0:00	Approved
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary.	0067 - Inpatient Psychiatric Facility Services - Complex Review	Inpatient Hospital	Claims with a "paid claim date" after 10-01-2015	2 - all applicable states	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); Title VIII of the Social Security Act (SSA): Section 1814 (a)(2)(A) and (4); Title XVIII of the Social Security Act (SSA): Section 1835 (a); CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 3 Federal Regulation References; 42 CFR 409.62; 42; CFR 412.404; CFR 424.14; 42 CFR 412.27 and 42 CFR 482.61 Other; Fourth Edition, Text Revision of the American Psychiatric Associations Diagnostic and Statistical Manual; ICD-10-CM codebook, Chapter 5 – Mental Disorders.	Complex	9/8/2017 0:00	Approved
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary.	0067 - Inpatient Psychiatric Facility Services - Complex Review	Inpatient Hospital	Claims with a "paid claim date" after 10-01-2015	3 - all applicable states	Title XVIII of the Social Security Act (SSA): Section 1833(e); Title XVIII of the Social Security Act (SSA), Section 1862(a)(1)(A); Title VIII of the Social Security Act (SSA): Section 1814 (a)(2)(A) and (4); Title XVIII of the Social Security Act (SSA): Section 1835 (a); CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4; CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2; CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 3 Federal Regulation References; 42 CFR 409.62; 42; CFR 412.404; CFR 424.14; 42 CFR 412.27 and 42 CFR 482.61 Other; Fourth Edition, Text Revision of the American Psychiatric Associations Diagnostic and Statistical Manual; ICD-10-CM codebook, Chapter 5 – Mental Disorders.	Complex	9/8/2017 0:00	Approved
Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician or physician group with the same specialty to the same patient.	0070 - Critical Care Billed on the Same Day as Emergency Room Services	Physician/NPP	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.12 (H) & (I)	Automated	10/5/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician or physician group with the same specialty to the same patient.	0070 - Critical Care Billed on the Same Day as Emergency Room Services	Physician/NPP	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, §30.6.12 (H) & (I)	Automated	10/5/2017 0:00	Approved
When administering multiple infusions, injections or combinations, the physician should only report one initial" service code unless protocol requires that two separate IV sites must be used. For these separate identifiable services, physicians need to report with using modifier 59, XE, XS, XP, or XU.	0071 - Initial Hydration, Infusion and Chemotherapy Administration	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.5(e), effective 6/26/2006	Automated	10/10/2017 0:00	Approved
When administering multiple infusions, injections or combinations, the physician should only report one initial" service code unless protocol requires that two separate IV sites must be used. For these separate identifiable services, physicians need to report with using modifier 59, XE, XS, XP, or XU.	0071 - Initial Hydration, Infusion and Chemotherapy Administration	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.5(e), effective 6/26/2006	Automated	10/10/2017 0:00	Approved
Payment may not be made for outpatient services overlapping or during an inpatient stay.	0072 - Outpatient Service Overlapping or During an Inpatient Stay	Outpatient Hospital	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Ch. 1, §120.2 (A), Ch.3, §40.3B Ch. 4, §200.2, Ch. 18, §10.2; Medicare Financial Management Manual: Publication 100-06; Ch. 3, §10.2; Medical Benefit Policy Manual: Publication 100-2; Ch. 6, §10.2	Automated	10/5/2017 0:00	Approved
Payment may not be made for outpatient services overlapping or during an inpatient stay.	0072 - Outpatient Service Overlapping or During an Inpatient Stay	Outpatient Hospital	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Ch. 1, §120.2 (A), Ch.3, §40.3B Ch. 4, §200.2, Ch. 18, §10.2; Medicare Financial Management Manual: Publication 100-06; Ch. 3, §10.2; Medical Benefit Policy Manual: Publication 100-2; Ch. 6, §10.2	Automated	10/5/2017 0:00	Approved
Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units.	0074 - Excessive or Insufficient Drugs and Biologicals Units Billed	Outpatient Hospital; Physician	3 years prior to the ADR Letter date	2 – all applicable states	Social Security Act, Section 1833 [42 U.S.C. 1395l] (e); 42 CFR §405.980 (b) and (c); 42 CFR §405.986; CMS IOM 100-04, Ch. 17, §§10, 40, 70 and 90.2; Medicare Alpha-Numeric HCPCS File; Annual American Medical Association: CPT Manual; Annual HCPCS Level II Manual; Medicare Part B Drug Average Sales Price; ASP Pricing File; U.S. National Library of Medicine DailyMed; Attached list of HCPCS Codes for Drugs and Biologicals	Complex	12/21/2017 0:00	Approved
Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Claims billed with excessive or insufficient units will be reviewed by a nurse, registered pharmacist, certified pharmacy technician, or certified coder to determine the actual amount administered and the correct number of billable/payable units.	0074 - Excessive or Insufficient Drugs and Biologicals Units Billed	Outpatient Hospital; Physician	3 years prior to the ADR Letter date	3 – all applicable states	Social Security Act, Section 1833 [42 U.S.C. 1395l] (e); 42 CFR §405.980 (b) and (c); 42 CFR §405.986; CMS IOM 100-04, Ch. 17, §§10, 40, 70 and 90.2; Medicare Alpha-Numeric HCPCS File; Annual American Medical Association: CPT Manual; Annual HCPCS Level II Manual; Medicare Part B Drug Average Sales Price; ASP Pricing File; U.S. National Library of Medicine DailyMed; Attached list of HCPCS Codes for Drugs and Biologicals	Complex	12/21/2017 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Except when reported with modifier 25, payment for certain evaluation and management services is bundled into the payment for dialysis services 90935, 90937, 90945, and 90947.	0076 - Evaluation and Management (E/M) Same Day as Dialysis	All physician/NPP specialties	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 8, § 170 (B)	Automated	1/11/2018 0:00	Approved
Except when reported with modifier 25, payment for certain evaluation and management services is bundled into the payment for dialysis services 90935, 90937, 90945, and 90947.	0076 - Evaluation and Management (E/M) Same Day as Dialysis	All physician/NPP specialties	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual: Publication 100-04; Chapter 8, § 170 (B)	Automated	1/11/2018 0:00	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventative Physical Examination (IPPE) has been paid within the previous 12 Months.	0077 - Annual Wellness Visits (AWV) billed within 12 months of (IPPE) or (AWV)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	2 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 18, § 140 effective 1/1/2011; 42 CFR Section 411.15(a)(1) and 411.15 (k)(15)	Automated	1/9/2018 0:00	Approved
The Annual Wellness Visit (AWV) is not payable if an Initial Preventative Physical Examination (IPPE) has been paid within the previous 12 Months.	0077 - Annual Wellness Visits (AWV) billed within 12 months of (IPPE) or (AWV)	Professional Services (Physician/Non-Physician)	3 years prior to the Informational Letter date	3 - all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 18, § 140 effective 1/1/2011; 42 CFR Section 411.15(a)(1) and 411.15 (k)(15)	Automated	1/9/2018 0:00	Approved
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Complex Cardiac Pacemaker Review	OP, ASC	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act (Section 1862(a)(1)(A)); 42 CFR §§405.980(b) and (c); 42 CFR §§ 405.986; CMS Pub. 100-03, Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3, Effective Date of this Version 8/13/2013; Cahaba Local Coverage Article A54949, Effective Date 4/15/2016; First Coast Local Coverage Article A54926, Effective date 5/1/2016; NGS Local Coverage Article A54909, Effective Date 4/15/2016; Novitas Local Coverage Article A54982, Effective Date 5/1/2016; Palmetto Local Coverage Article A54831, Effective Date 01/13/2016; WPS Local Coverage Article A54958, Effective Date 5/15/2016; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018 0:00	Approved
Documentation will be reviewed to determine if Cardiac Pacemakers meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0078 - Complex Cardiac Pacemaker Review	OP, ASC	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act (Section 1862(a)(1)(A)); 42 CFR §§405.980(b) and (c); 42 CFR §§ 405.986; CMS Pub. 100-03, Medicare National Coverage Determinations (NCD), Ch. 1, Part 1, §20.8.3, Effective Date of this Version 8/13/2013; Cahaba Local Coverage Article A54949, Effective Date 4/15/2016; First Coast Local Coverage Article A54926, Effective date 5/1/2016; NGS Local Coverage Article A54909, Effective Date 4/15/2016; Novitas Local Coverage Article A54982, Effective Date 5/1/2016; Palmetto Local Coverage Article A54831, Effective Date 01/13/2016; WPS Local Coverage Article A54958, Effective Date 5/15/2016; Annual American Medical Association CPT Manual, Coding Guidelines	Complex	2/15/2018 0:00	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. This query identifies overpayments where providers are billing for more than one unit of cataract removal for the same eye, on the same line of the claim.	0083 - Cataract Removal Excessive Units - Partial Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
Cataract removal cannot be performed more than once on the same eye on the same date of service. This query identifies overpayments where providers are billing for more than one unit of cataract removal for the same eye, on the same line of the claim.	0083 - Cataract Removal Excessive Units - Partial Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
CPT Codes describing cataract extraction are mutually exclusive of one another. Only one code from the affected CPT code range may be reported per date of service and for each eye.	0084 - Cataract Removal Excessive Units - Full Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
CPT Codes describing cataract extraction are mutually exclusive of one another. Only one code from the affected CPT code range may be reported per date of service and for each eye.	0084 - Cataract Removal Excessive Units - Full Denial	Physician/Non-Physician Practitioner, Outpatient, ASC	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Title XVIII of the Social Security Act: Section 1862(a)(1)(A); National Correct Coding Initiative (NCCI) Policy Manual (Chapter 8, Section D)	Automated	3/14/2018 0:00	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services, according to CMS IOM 100-04 Chapter 3, section 10.4	0085 - Lab Services Rendered During an Inpatient Stay	Laboratory	3 years prior to the Informational Letter date	2 – all applicable states	CMS IOM 100-04 Chapter 3, section 10.4; CPT Coding Book	Automated	3/13/2018 0:00	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services, therefore if billed separately should be denied as unbundled services, according to CMS IOM 100-04 Chapter 3, section 10.4	0085 - Lab Services Rendered During an Inpatient Stay	Laboratory	3 years prior to the Informational Letter date	3 – all applicable states	CMS IOM 100-04 Chapter 3, section 10.4; CPT Coding Book	Automated	3/13/2018 0:00	Approved
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) codes billed Same Day as Inpatient Admission	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.8 (D)	Automated	3/14/2018 0:00	Approved
Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill observation care codes (initial, subsequent and/or discharge management) for services on the date that he or she admits the patient to inpatient status.	0086 - Observation Evaluation & Management (E&M) codes billed Same Day as Inpatient Admission	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: Publication 100-04; Chapter 12, § 30.6.8 (D)	Automated	3/14/2018 0:00	Approved
The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these laboratory services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system.	0087 - Labs Subject to Part B Consolidated Billing for Clinical Labs - ESRD	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual 100-04; Chapter 8, Section 60.1 (effective 4/01/2015); ESRD PPS Consolidated Billing (files for 2014 – 2017) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018 0:00	Approved
The ESRD PPS includes consolidated billing for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these laboratory services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted with the new AY modifier to allow for separate payment outside of ESRD prospective payment system.	0087 - Labs Subject to Part B Consolidated Billing for Clinical Labs - ESRD	Professional Services (Physician/Non-Physician Practitioner)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Medicare Claims Processing Manual 100-04; Chapter 8, Section 60.1 (effective 4/01/2015); ESRD PPS Consolidated Billing (files for 2014 – 2017) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html	Automated	3/14/2018 0:00	Approved

Description	Issue Name	Claim Type	Date of Service	Regions and States	Additional Information	Issue Type	Date Approved	Approval Status
Covered ancillary items and services identified in Appendix D are not payable if there is no approved ASC surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 14, § 40	Automated	3/14/2018 0:00	Approved
Covered ancillary items and services identified in Appendix D are not payable if there is no approved ASC surgical procedure on the same claim or in history for the same date of service and same provider.	0088 - Ancillary Services Billed Without an Approved Surgical Procedure	Ambulatory Surgery Center (ASC)	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 14, § 40	Automated	3/14/2018 0:00	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - CSW (Clinical Social Workers) during Inpatient Hospital	Clinical Social Workers	3 years prior to the Informational Letter date	2 – all applicable states	42 CFR 409.10 (a)(4); 42 CFR 410.73; 42 CFR 412.50 (b); Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Title XVIII of the Social Security Act, Section 1861 (hh) and (hh)(2). [42 U.S.C. 13951]; Medicare Benefit Policy Manual 100-02; Chapter 15, Section 170 ; Medicare Claims Processing Manual 100-04; Chapter 3, Section 10.4;WPS Local Coverage Article A54829; Effective 02/01/2016	Automated	3/14/2018 0:00	Approved
Services of Clinical Social Workers (CSW) rendered during Inpatient Hospital stays are included in the facilities PPS payment and are not separately payable under Part B. CSW providers are expected to seek reimbursement from the facility.	0089 - CSW (Clinical Social Workers) during Inpatient Hospital	Clinical Social Workers	3 years prior to the Informational Letter date	3 – all applicable states	42 CFR 409.10 (a)(4); 42 CFR 410.73; 42 CFR 412.50 (b); Title XVIII of the Social Security Act, Section 1833. [42 U.S.C. 1395l] (e); Title XVIII of the Social Security Act, Section 1861 (hh) and (hh)(2). [42 U.S.C. 13951]; Medicare Benefit Policy Manual 100-02; Chapter 15, Section 170 ; Medicare Claims Processing Manual 100-04; Chapter 3, Section 10.4;WPS Local Coverage Article A54829; Effective 02/01/2016	Automated	3/14/2018 0:00	Approved
The technical component (TC) of lab/pathology services furnished to patients in an outpatient hospital setting are not separately payable. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator “3” for TC component only.	0090 - Technical Component of Lab/Pathology for Outpatient Hospitals	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	2 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual 100-04; Chapter 23; File Layout	Automated	4/4/2018	Approved
The technical component (TC) of lab/pathology services furnished to patients in an outpatient hospital setting are not separately payable. Findings are limited to claim lines billed with modifier TC and claim lines for service codes with TC/PC Indicator “3” for TC component only.	0090 - Technical Component of Lab/Pathology for Outpatient Hospitals	Physician/Non-Physician Practitioner	3 years prior to the Informational Letter date	3 – all applicable states	Title XVIII of the Social Security Act: Section 1833(e); Medicare Claims Processing Manual 100-04; Chapter 23; File Layout	Automated	4/4/2018	Approved
Providers that submit and were paid for code, 64553 and/ or code 64555 must support in the documentation that the code billed was actually the service rendered and that all coverage criteria were met.	0092 - Medical Necessity Review Percutaneous Implantation of Neurostimulator Electrode Array	Outpatient Hospital, (OPH); Ambulatory Surgery Center (ASC);	3 years prior to ADR Letter date	2 – all applicable states	Social Security Act: Section 1833(e) ; 42 Code of Federal Regulations §411.15(k)(1); Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §160.7.1 (Updated through Rev. 181, Effective: 12/18/14; Issued: 03/27/15); Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §30.3 (Rev. 1, 10-03-03); American Medical Association Current Procedural Terminology Manual/ Healthcare Common Procedure Coding System 2014 to current	Complex	5/8/2018	Approved
Providers that submit and were paid for code, 64553 and/ or code 64555 must support in the documentation that the code billed was actually the service rendered and that all coverage criteria were met.	0092 - Medical Necessity Review Percutaneous Implantation of Neurostimulator Electrode Array	Outpatient Hospital, (OPH); Ambulatory Surgery Center (ASC);	3 years prior to ADR Letter date	3 – all applicable states	Social Security Act: Section 1833(e) ; 42 Code of Federal Regulations §411.15(k)(1); Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §160.7.1 (Updated through Rev. 181, Effective: 12/18/14; Issued: 03/27/15); Centers for Medicare & Medicaid Services, Internet Only Manual 100-3, National Coverage Determination §30.3 (Rev. 1, 10-03-03); American Medical Association Current Procedural Terminology Manual/ Healthcare Common Procedure Coding System 2014 to current	Complex	5/8/2018	Approved