Cotiviti Approved Topics List as of May 1, 2025

All physician/NPP specialties	32
Ambulance Providers	34
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Outpatient Hospital, Inpatient Hospital	61
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Physician, Outpatient Hospital, Professional Services	70
Physician, Professional Services	72
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Physician/Non-physician Practitioner	80
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Professional Services (Physician/Non-Physician)	86
Radiologists/Part B providers doing radiology service	110
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Description	Review Topic	Claim Type	Date of Service	Regions and States	Additional Information	Review 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	0001 - Inpatient Hospital MS-DRG Coding Validation	Inpatient Hospital	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the Review Results letter date.	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	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	Outpatient Hospital (OP), Ambulatory Surgery Center (ASC)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	2/12/2017	Approved
Documentation will be reviewed to determine if sacral nerve stimulation for urinary or fecal incontinence meets Medicare coverage criteria, and/or is medically reasonable and necessary.	0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Inpatient Hospital- acute care, Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner), Ambulatory Surgery Center	Exclude from review claims having a "paid claim date" which is more than 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	Complex	1/23/2017	Approved
The surgical management for the treatment of morbid obesity is considered reasonable and necessary for Medicare beneficiaries who have a BMI ≥ 35, have at least one co-morbidity related to obesity and have been previously unsuccessful	0008 - Bariatric Surgery: Medical Necessity and Documentation Requirements	Outpatient Hospital; Inpatient Hospital	Exclude from review claims having a "paid claim date" which is more than 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	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)	Exclude from review claims having a "paid claim date" which is more than 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	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)	Claims that have a "claim paid date" which is less than 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 5405.920- Post Payment Review	Automated	1/29/2017	Approved
Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a	0022 - Inpatient Psychiatric Admission Billed without Source of Admission Equal to "D"	Inpatient Hospital, Inpatient Psychiatric Facility	Claims that have a "claim paid date" which is less than 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
Claims for HCPCS code G0438 billed more than once in a lifetime will be denied. HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) is a "one time" allowed Medicare benefit per beneficiary.	0028 - Annual Wellness Visits: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	Exclude from the automated review claims having a paid claim date more than 3 years prior to the Review Results Letter.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3.42 CFR 5405.920- Post Payment Review	Automated	4/26/2017	Approved
Both Initial Hospital Care codes (CPT codes 99221–99223) and Subsequent Hospital Care codes (CPT Codes 99231 99233) are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from	0037 - Hospital Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	Exclude claims having a paid claim date which is more than 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	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 codes	0038 - Visits to Patients in Swing Beds: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a paid claim date which is more than 3 years prior to the Informational Results Letter (IRL) date.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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.	0039 - Ophthalmology Codes for New Patient: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Algorithm excludes from this automated review, claims having a paid claim date which is more than 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	3/23/2017	Approved
Office or other outpatient visits for evaluation and management services cannot be billed for patients while they are admitted to a hospital setting. Billing these services incorrectly will result in an overpayment and the amount will be	0042 - Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" less than 6 months prior to the informational Letter date (automated review).	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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.	0043 - New Patient Visits: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 6 months prior to the Review Results Letter.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	3/23/2017	Approved
Algorithm identifies all paid Ambulance Claims billed with one of the following HCPCS codes: A0426, A0427, A0428, A0429, with modifier NN on the same line, for SNF claims. Under the prospective payment system, some ambulance	0049 - Ambulance Transfer between Skilled Nursing Facilities: Unbundling	Ambulance Providers and Suppliers	Claims that have a claim paid date which is less than 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	8/8/2017	Approved

Description	Review Topic	Claim Type	Date of Service	Regions and States	Additional Information	Review 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. Add-on codes paid without a paid or	0050 - Add-on Codes Paid without Primary Code and/or Denied Primary Code	Professional Services (Physician/Non-Physician Practitioners); Outpatient Hospital	Exclude claims that have a "claim paid date" which is more than 3 years prior to the Informational Letter date (automated review).	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	1/22/2021	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	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	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	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	0056 - Evaluation and Management Services in Skilled Nursing Facilities: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	8/7/2017	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 (CORF)	Exclude from this automated review, claims having a paid claim date which is more than 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	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	0061 - Nursing Facility Services: Excessive Units	Professional Services (Physician/Non-Physician Practitioner)	Exclude claims having a paid claim date which is more than 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	Automated	9/8/2017	Approved
Carriers may not pay for the technical component (TC) of radiology services furnished to patients during inpatient stay. Query identifies TC portion of radiology paid to entities other than the inpatient facility. Findings are limited to	0062 - Radiology: Technical Component during Inpatient Stay	Radiologists/Part B providers performing radiology services	Exclude claims that have a claim paid date which is more than 3 years prior to the review results letter date.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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)	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the Review Results Letter date.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	9/8/2017	Approved
Inpatient hospital services furnished to a patient of an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Services found to be not medically reasonable and necessary will result	0067 - Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements	Inpatient Hospital (IP); Inpatient Psychiatric Facility (IPF)	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the Review Results letter date	3 – all applicable states	1.Title XVIII of the Social Security Act (SSA), Section 1814(a)(2)(A) and (4)- Conditions of and Limitations on Payment for Services 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1815(a)- Payment to Providers of Services	Complex	9/8/2017	Approved
Outpatient services for the same beneficiary, same or different service provider, where the date(s) of service on the outpatient claim falls within an inpatient admission or overlap the admission date of the inpatient claim are considered	0072 - Outpatient Service Overlapping or During an Inpatient Stay: Duplicate Payments	Outpatient Hospital; Inpatient Hospital Part B	Claims having a "claim paid date" that is more than 3 years prior to the informational letter date will be excluded.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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	0073 - Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements	Inpatient Rehabilitation Facility; Inpatient	Exclude from review claims having a "paid claim date" which is more than 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, §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	Complex	10/4/2018	Approved
Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.	0074 - Drugs and Biologicals in Single-Dose Vials: Incorrect Units Billed	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	12/21/2017	Approved
Claims for HCPCS Code G0439 will be recovered as overpayment as it is not payable if an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV) has been paid within the past eleven (11) whole months.	0077 - Annual Wellness Visit Billed Sooner than Eleven Whole Months Following the Initial Preventive Physical Examination	Part B Professional Services (Physician/Non-Physician Practitioner)	Claims having a "claim paid date" that is more than 3 years prior to the Review Results letter date will be excluded.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	1/9/2018	Approved
Laboratory services are covered under Part A, excluding anatomic pathology services and certain clinical pathology services. If billed separately, these are considered unbundled services.	0085 - Laboratory Services Rendered During an Inpatient Stay: Unbundling	Laboratory/Ambulance, Outpatient Hospital	Select claims that have a "claim paid date" which is less than 3 years prior to the Review Results Letter date.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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	0086 - Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the Informational Letter date and dates of service on and after 1/1/2023	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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 are not separately payable when provided for ESRD beneficiaries by providers other than the renal	0087 - Laboratory Services for End-Stage Renal Disease Subject to Part B Consolidated Billing: Unbundling	Professional Services (Physician/Non-Physician Practitioner)	Claims having a "claim paid date" that is more than 3 years prior to the Informational letter date will be excluded	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits 3.42 CFR 5405.920- Post Payment Review	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)	Claims having a "claim paid date" that is more than 3 years prior to the Informational letter date will be excluded.	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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)	Claims having a "claim paid date" that is more than 3 years prior to the Informational Letter date will be excluded.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section §1861(hh)- Clinical Social Worker,	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)	Exclude from this automated review, claims having a paid claim date which is more than 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	4/4/2018	Approved
Duplicate payments are any payments paid across more than one claim number for the same Beneficiary, CPT/HCPCS code, and service date by the same provider, in excess of a code's Medically Unlikely Edit (MUE).	0091- Duplicate Payments: Professional Services	Part B Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	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	5/8/2018	Approved
The review shall identify claims billed incorrectly as percutaneous implantation of neurostimulator electrode arrays when the medical record demonstrates the transcutaneous placement of a device.	0092 - Percutaneous Implantation of Neurostimulator Electrode Array: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	Claims having a "paid claim date" which is less than 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	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	0093 - Implantable Automatic Defibrillators- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital, ASC (TOB 13X and 83X), ASC (ASC facilities = service type 'F')	Exclude from review claims having a "paid claim date" which is more than 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 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	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	Hospital Inpatient (Part B) – 12X, Outpatient – 13X, Ambulatory Surgery (ASC) – 83X or POS 24 with TOS F	Exclude claims that have a "claim paid date" which is more than 3 years prior to the ADR letter date (complex review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	2/1/2023	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	Part B Professional Services (Physician/Non-Physician Practitioner)	Claims that have a claim paid date which is less than 3 years prior to the informational letter date (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	6/18/2018	Approved

Description	Review Topic	Claim Type	Date of Service	Regions and States	Additional Information	Review Type	Date Approved	Approval Status
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	0099 - Skilled Nursing Facility Consolidated Billing: Unbundling	Outpatient Facility	Exclude claims having a "claim paid date" which is more than 3 years prior to the informational letter (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	6/25/2018	Approved
CMS has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed. Clinical Laboratory providers paid for Add-On HCPCS/CPT codes without the required Primary code for Denial Diagno	0100 - Add-On Code Paid without Primary Code and/or Denied Primary Code: Clinical Laboratory	Laboratory	Claims that have a "claim paid date" which is less than 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 §405.920–Part B Payment Review	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 (Part B)	Exclude from review claims having a "paid claim date" which is more than 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	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)	Claims that have a "claim paid date" which is less than 3 years prior to the informational letter date (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	7/24/2018	Approved
Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and non-facility settings. The rate, facility or non-facility, which a physician service is paid under	0108 - Facility vs Non-Facility Reimbursement: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims having a "claim paid date" that is more than 6 months prior to the informational letter date will be excluded.	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	9/11/2018	Approved
When a Part B CPT/HCPCS code listed on File 2 (Professional Components of Services to be Submitted with a 26 Modifier) is billed during a paid inpatient Part A SNF stay, without modifier 26, the Part B claim will be repriced with modifier 26 to	0110 - Skilled Nursing Facility Consolidated Billing: Part B – Use of Modifier 26, Professional Component	Professional Services (Physician/Non-Physician Practitioner)	Include Claims that have a "claim paid date" which is less than 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	9/20/2018	Approved
Documentation will be reviewed to determine if transthoracic echocardiography meets Medicare coverage criteria, meets applicable coding guidelines, and/or is reasonable and necessary.	0111 - Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	Inpatient Hospital (Medicare Part B only) (TOB 12X), Outpatient Hospital (TOB 13X) , Skilled Nursing Facility - Inpatient (Medicare Part B only)(TOB 22X)	Claims that have a "paid claim date" which is less than 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 1862(a)(7)-Exclusions from	Complex	9/28/2018	Approved
Home Visits for professional services should not overlap an active Inpatient Stay. Professional claims billed with a home-related place of service that overlaps an inpatient hospital stay will be denied.	0115 - Professional Claims with Place of Service Home Overlapping Inpatient Hospital Stay: Services Billed Not Rendered	Professional Claims (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	10/17/2018	Approved
HCPCS Codes with a PC/TC Indicator of "1" and billed with either 26 or TC in any modifier field should be paid at either the technical component or the professional component rate based on the modifier billed. Overpayments occur	0116 - Modifiers TC and 26: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review)	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	10/9/2018	Approved
Epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of	0119- Epidural Steroid Injection: Medical Necessity and Documentation Requirements	Professional services, Outpatient Hospital	Exclude claims having a "claim paid date" which is more than 3 years prior to the Additional Documentation Request Letter	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	9/12/2024	Approved
When billed on the same date of service as an inpatient hospital claim, the Technical Component (TC) of diagnostics is not payable to the Part B provider. The technical component is performed by the facility while a patient is in a covered	0123 - Technical Component of Diagnostic Procedures During Inpatient: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Independent Diagnostic Testing Facility (IDTF)	Claims that have a "claim paid date" which is less than 3 years prior to the informational results letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	12/11/2018	Approved
HCPCS/CPT Codes with a PC/TC Indicator "7" in the Medicare Physician Fee Schedule Data Base. Payment may not be made if the service is provided to a hospital inpatient by a physical therapist, occupational therapist, or speech	0124 - Part B Therapies during Inpatient: Unbundling	Professional Services (Physical Therapist, Occupational Therapist, Speech Language Therapist in Private Practice)	Claims having a "claim paid date" which is less than 3 years prior to the informational letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	11/30/2018	Approved
Surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code shall not be reported with a surgical endoscopy code. If multiple endoscopic services are performed, the most comprehensive code describing the	0126 - Endoscopy Procedures: Diagnostic and Surgical Billed Same Day	Outpatient Facility; Ambulatory Surgery Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the date of the Informational Letter.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	11/14/2018	Approved
For purposes of coverage under Medicare, Hyperbaric Oxygen Therapy (HBOT) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The patient is entirely enclosed in a pressure chamber	0129 - Hyperbaric Oxygen Therapy for Diabetic Wounds: Medical Necessity and Documentation Requirements	Outpatient Hospital TOB: 13X	Exclude from review claims having a "paid claim date" which is more than 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	Complex	1/30/2019	Approved
Panniculectomy billed for cosmetic purposes will not be deemed medically necessary. In addition, panniculectomy billed at the same time as an open abdominal surgery, or if is incidental to another procedure, is not separately	0130 - Panniculectomy: Medical Necessity and Documentation Requirements	Ambulatory Surgical Center; Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 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	Complex	2/13/2019	Approved
Documentation will be reviewed to determine whether Cryosurgery of the Prostate Gland services met Medicare coverage criteria and were reasonable and necessary.	0134 - Cryosurgery of the Prostate: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center, and Professional Services (Physician/Non-Physician Practitioner)	Exclude claims having a "paid claim date" which is more than 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	Complex	2/5/2019	Approved
Cardiac rehabilitation (CR) is a physician or non-physician practitioner-supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention;	0135 - Cardiac Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital (TOB 13X)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	3/7/2019	Approved
Radiographs of the chest are common tests performed in many outpatient offices (radiology and many others), clinics, outpatient hospital departments, inpatient hospital episodes, skilled nursing facilities, homes, and other settings. They can be	0136 - Radiologic Examination of the Chest: Medical Necessity and Documentation Requirements	Outpatient Hospital (TOB 13X)	Exclude from review claims with Dates of Service prior to May 12, 2023	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	4/15/2019	Approved
Physical therapy, Occupational therapy, and/or Speech-Language pathology services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional, are bundled into the SNF's global per	0138 - Skilled Nursing Facility Consolidated Billing for Therapies: Unbundling	Professional Services (Physician/Non-Physician Practitioner); Physical Therapist; Occupational Therapist; Speech-language Pathologist	Exclude claims having a "claim paid date" which is more than 3 years prior to the informational letter date (automated review).	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	Automated	2/20/2019	Approved
Vertebroplasty and kyphoplasty will be reviewed for medical necessity whether billed as an initial procedure, a repeat procedure (beyond once in a lifetime) or if performed at more than one vertebral level.	0139 - Vertebroplasty or Kyphoplasty: Medical Necessity and Documentation Requirements	Outpatient Hospital (OPH), Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)	Claims having a "paid claim date" which is less than 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	Complex	2/20/2019	Approved
Pulmonary rehabilitation (PR) is a physician or nonphysician practitioner-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Medical	0140 - Pulmonary Rehabilitation: Medical Necessity and Documentation Requirements	Outpatient Hospital (TOB 13X)	Exclude from review claims with Dates of Service prior to May 12, 2023	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	3/27/2019	Approved
Services provided by a freestanding non-hospital ASC (Ambulatory Surgery Center) are included under the SNF Consolidated Billing Provisions. Certain services are not payable because they are included in SNF Consolidated Billing. Codes found in	0142 - Ambulatory Surgical Center Services Billed During a Covered Part A Skilled Nursing Facility Stay: Unbundling	Ambulatory Surgical Center (ASC), Skilled Nursing Facility (SNF)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	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	Automated	4/2/2019	Approved
Documentation will be reviewed to determine if claims for Endovenous Radiofrequency Ablation (ERFA) and Endovenous Laser Treatment (EVLT) for Lower Extremity Varicose Veins meet Medicare coverage criteria, meets applicable	0145 - Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity and Documentation Requirements	Ambulatory Surgical Center (ASC), Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	4/2/2019	Approved

Description	Review Topic	Claim Type	Date of Service	Regions and States	Additional Information	Review Type	Date Approved	Approval Status
When a more extensive CT Scan is performed on the same site as a less extensive CT Scan, the less extensive CT Scan is bundled into the more extensive CT Scan.	0146 - Computed Tomography Scans: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	Claims that have a "paid claim date" which is less than 3 years prior to the Informational Letter Date (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	3/27/2019	Approved
When a more extensive Magnetic Resonance Imaging (MRI) Procedure is performed on the same site as a less extensive MRI procedure, the less extensive MRI procedure is bundled into the more extensive MRI procedure.	0147 - Magnetic Resonance Imaging Procedures: Excessive Units	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital	Claims that have a "claim paid date" which is less than three years prior to the informational Letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	3/29/2019	Approved
CMS does not reimburse both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. CPT codes 99231 – 99233 will be considered overpayments and will be recovered.	0149 - Subsequent Hospital Visit and Discharge Day Management on the Same Day: Unbundling	Professional Services (Physician/Non-Physician Practitioner); exclude non-physician practitioner codes 50 (NP) and 97 (PA)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A) - Exclusions from Coverage and Medicare 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	4/22/2019	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	0150 - Mohs Micrographic Surgery: Incorrect Coding and Incorrect Units Billed	Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	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	0151 - Physician/Non-Physician Practitioner Coding Validation	Professional Services (Physician/Non-Physician Practitioner)	Exclude claims that have a "paid claim date" which is more than 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	Complex	4/24/2019	Approved
Ambulatory Surgical Center (ASC) coding requires that the procedural information, as coded and reported by the ASC on its claim, match both the physician description and the information contained in the beneficiary's medical record.	0153 - Ambulatory Surgical Center Coding Validation	Ambulatory Surgical Center (ASC)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	5/28/2019	Approved
Medical documentation for ambulance services will be reviewed to determine the Medicare defined conditions have been met for payment.	0154 - Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements	Ambulance Providers, Carrier claims with provider specialty code 59.	Exclude from review claims having a "paid claim date" which is more than 3 years prior to ADR Letter date as well as state/date exclusions;	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	5/22/2019	Approved
Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is	0157 - Discontinued Procedure Prior to the Administration of Anesthesia: Documentation Requirements	Hospital Outpatient (TOB 13X); Ambulatory Surgery Center (Place of Service 24 with Type of Service "F")	Exclude from review claims having a "claim paid date" which is more than 3 years prior to the ADR date	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	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	0158 - Outpatient Therapy Services During Home Health: Unbundling	Hospital Outpatient (Type of Bill (TOB) 13x), Skilled Nursing Facility (SNF) Outpatient (TOB 23x), Outpatient Rehabilitation Facility (TOB 24x)	Claims that have a "claim paid date" which is less than 3 years prior to the informational Letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	7/15/2019	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.	0160 - Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioner)	Exclude claims having a "paid claim date" which is more than 3 years prior to the Review Results letter date.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	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	Exclude from review claims having a "paid claim date" which is more than 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	Complex	11/18/2019	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	0164 - Bilateral Indicator '3': Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Review Results Letter.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	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	0165 - Positron Emission Tomography for Dementia and Neurodegenerative Diseases: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 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	Complex	9/25/2019	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	0169 - Outpatient Services within 3 Days Prior to and Including the Date of a Hospital Admission: Unbundling	Outpatient Facility	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	11/27/2019	Approved
Documentation will be reviewed to determine if diagnostic (aka stand-alone) renal and peripheral angiography procedures meet Medicare coverage criteria, meet applicable coding guidelines, and/or are medically reasonable and necessary.	0170 - Renal and Peripheral Angiography: Medical Necessity and Documentation Requirements	Outpatient Hospital (OPH); Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	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	0171 - Erythropoiesis Stimulating Agents for Cancer Patients: Medical Necessity and Documentation Requirements	Professional Services (Physician/Non-Physician Practitioner); Outpatient Hospital (TOB 13X)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	12/27/2019	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	0182 - Reduction of Technical Component, Diagnostic Cardiovascular Services	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the informational Letter date (automated review).	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	8/3/2020	Approved
Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or	0183 - Specialty Care Transport: Medical Necessity and Documentation Requirements	Ambulance, Carrier claims with provider specialty code 59	Exclude from review claims having a "paid claim date" which is more than 6 months 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	Complex	8/3/2020	Approved
Documentation will be reviewed to determine if total hip arthroplasty meets Medicare coverage requirements.	0184 - Total Hip Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	Claims that have a "claim paid date" which is less than 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	Complex	8/3/2020	Approved
Documentation will be reviewed to determine if total knee arthroplasty meets Medicare coverage requirements.	0185 - Total Knee Arthroplasty: Medical Necessity and Documentation Requirements	Inpatient Hospital, Outpatient Hospital, Ambulatory Surgical Center, Professional Services (Physician/Non-physician Practitioner)	Claims that have a "claim paid date" which is less than 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	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	0186 - Duplex Scans of Extracranial Arteries: Medical Necessity and Documentation Requirements	Outpatient Hospital	Review claims having a "paid claim date" which is less than 3 years prior to the Review Results letter date	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	8/3/2020	Approved
Documentation will be reviewed to determine if the use of nerve conduction studies meet coverage criteria and /or are medically reasonable and necessary.	0187 - Nerve Conduction Studies: Excessive Units	Outpatient Hospital	Exclude claims having a "paid claim date" which is more than 3 years prior to the 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	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) with TOB 21X	Claims having a "claim paid date" which is more than 3 years prior to the ADR date will be excluded.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	7/20/2022	Approved

Description	Review Topic	Claim Type	Date of Service	Regions and States	Additional Information	Review Type	Date Approved	Approval Status
This review will determine if polysomnography is reasonable and necessary for the patient's condition based on the documentation in the medical record.	0191 - Polysomnography: Medical Necessity and Documentation Requirements	Outpatient Hospital	Exclude from review claims having a "paid claim date" which is more than 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 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	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	0192 - Ventricular Assist Device: Medical Necessity and Documentation Requirements	Inpatient Hospital	Exclude from review claims with Dates of Service prior to May 12, 2023	3 – all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	9/25/2020	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	0195 - Implantable Automatic Defibrillators- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital (TOB 11X)	Exclude from review claims having a "paid claim date" which is more than 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	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	0196 - Deep Brain Stimulation- Outpatient Procedure: Medical Necessity and Documentation Requirements	Outpatient Hospital; Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	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	0198 - Deep Brain Stimulation- Inpatient Procedure: Medical Necessity and Documentation Requirements	Inpatient Hospital	Exclude from review claims having a "paid claim date" which is more than 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	Complex	11/18/2020	Approved
This complex review will be examining rotatory wing (helicopter) aircraft claims to determine if air ambulance transport was reasonable and medically necessary as well as whether documentation requirements have been met.	0200 - Air Ambulance: Medical Necessity and Documentation Requirements	Ambulance Providers	Claims that have a "claim paid date" which is less than 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	Complex	2/4/2021	Approved
Certain ambulance services are included in SNF consolidated billing and may not be billed as Part B services to the A/B MAC, when the beneficiary is in a Part A stay.	0202 - Skilled Nursing Facility (SNF) Consolidated Billing for Ambulance Transports: Unbundling	Ambulance Providers (specialty code 59)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review)	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	2/4/2021	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)	Claims having a "claim paid date" that is more than 3 years prior to the ADR date will be excluded.	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	Complex	3/11/2021	Approved
Next Generation Sequencing (NGS) as a diagnostic laboratory test is reasonable and necessary and covered nationally, when performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory, when ordered by a	0205 - Next Generation Sequencing: Medical Necessity and Documentation Requirements	Laboratory Services	Exclude claims having a "paid claim date" which is more than 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 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 Payer42 CFR §405.929- Post-Payment Review	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	0206 - Positron Emission Tomography for Initial Treatment Strategy in Oncologic Conditions: Medical Necessity and Documentation Requirements	Outpatient Hospital, Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 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 Benefit	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)	Claims having a "paid claim date" which is less than 3 years prior to the ADR letter date and DOS on or after January 1, 2022	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	Complex	6/29/2022	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	Outpatient Hospital, Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	4/26/2023	Approved
Documentation will be reviewed to determine if CPT code 15734 warranted separate reimbursement given that a flap is considered inclusive to breast reconstruction (19357-19364, 19367-19369) or breast prosthesis (19340, 19342)	0217 - Muscle Flap with Breast Reconstruction or Breast Prosthesis Insertion: Unbundling	Physician/Non-physician Practitioner (NPP)	Exclude from review claims having a "paid claim date" which is more than 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	Complex	6/6/2023	Approved
Documentation will be reviewed to determine whether minimally invasive surgical fusion of the sacroiliac joint met Medicare coverage criteria and was reasonable and necessary.	0219 - Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac Joint: Medical Necessity and Documentation Requirements	Outpatient Hospital, Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)	Claims having a "paid claim date" which is less than 3 years prior to the ADR letter date. JJ and JM are limited to DOS on/after 7/17/2022.	3 – all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer 2.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1833(e)- Payment of Benefits	Complex	6/6/2023	Approved
Assistant at surgery services by non-physician providers (PA, NP, or CNS), are reimbursed at 85 percent of 16 percent (i.e., 13.6 percent) of the Medicare Physician Fee Schedule Data Base amount. Modifier "AS" is used for assistant at	0222- Non-Physician Billed Without Correct Assistant at Surgery Modifier: Incorrect Coding	Professional Services (Physician/Non-Physician Practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health 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	6/24/2024	Approved
The JW modifier is a Healthcare Common Procedure Coding System (HCPCS) Level II modifier required to be reported on a claim to report the amount of drug that is discarded and eligible for payment under the CMS discarded drug policy. The	0223- Drugs and Biologicals in Multi-Dose Vials: Billed with JW Modifier	Outpatient Hospital, Professional Services	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review).	3 - all applicable states	1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	11/4/2024	Approved
A physician or other qualified health care professional who reports Transitional Care Management CPT code 99495 or 99496 may not report telephone service (CPT code 99441-99443) during the time period covered by the transitional care	0024- Transitional Care Management: Unbundling	Professional Services (Physician/non-physician practitioner)	Claims that have a "claim paid date" which is less than 3 years prior to the Informational Letter date (automated review)	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	1/14/2025	Approved
Medicare may cover transitional care services during the 30-day period that begins when a physician discharges a Medicare patient from a healthcare facility and continues for the next 29 days. Only one of the Transitional Care	0225- Transitional Care Management: Excessive Units	Professional Services (Physician/non-physician practitioner)	Exclude from review claims having a "paid claim date" which is more than 3 years prior to the date of the Informational Letter.	3 - all applicable states	1.Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare 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	1/13/2025	Approved