eGlobalTech

CBR201604

Non-invasive Vascular Studies

Webinar Handout

April 13, 2016
3:00 p.m. ET

CPT® codes, descriptors, and other data are copyright 2014/2015 American Medical Association.
All Rights Reserved. Applicable FARS/DFARS apply.
CONTENTS

INTRODUCTION.................................................................................................................................................................3

COVERAGE & DOCUMENTATION OVERVIEW .........................................................................................................................7

METHODS & RESULTS...............................................................................................................................................................22

REFERENCES & RESOURCES......................................................................................................................................................29

QUESTIONS & ANSWERS..........................................................................................................................................................34

REFERENCE & RESOURCE WEB LINKS......................................................................................................................................35
INTRODUCTION

Good afternoon, everyone, and welcome to the Comparative Billing Report (CBR) webinar to discuss CBR201604 on Non-invasive Vascular Studies. My name is Molly Wesley, and I am with eGlobalTech. We, along with our partner, Palmetto GBA, have been contracted by the Centers for Medicare & Medicaid Services (CMS) to produce and distribute CBRs. We are responsible for conducting the statistical analyses central to the data contained in each CBR, developing and disseminating the reports, ensuring data integrity and privacy, and providing customer service and educational outreach opportunities.

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements. CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR material is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) for the A/B Medicare Administrative Contractors (MACs) or DME Medicare Administrative Contractors (DME MACs).

Please refer any specific questions you may have to the A/B or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. All coverage and documentation policies are located on the CMS website page titled, Medicare Coverage Database [https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&ss=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAA%3d%3d%3d%3d%3d%3d].
Today, we are going to give you a general overview of CBR201604. Our overview will include coverage policy and documentation requirements for items included in the topic, the methods used to produce the report, source references, and additional resources available to you. Then, we will be taking your questions at the end of the presentation. At the conclusion of the Question and Answer (Q&A) session, we will provide you with a brief survey to complete. We welcome and value your feedback. The Q&A can be found on the CBR website page, Questions and Answers (http://www.cbrinfo.net/assets/cbr201604-questions-and-answers.pdf).

Now that we have gone over the agenda for today’s webinar, we would like to get your response to a poll question. During today’s presentation, we will be asking five poll questions, and we will give you approximately 30 seconds to respond to each question. We are now ready for our first poll question.

**POLL QUESTION**

*What is your role in the Medicare program for your facility?*

- Clinician
- Biller
- Compliance
- Administrator
- Other

Now that we have all of your answers, we will continue with our presentation. Thank you for your participation.

Please note that during the webinar, all attendee lines will be muted. After the presentation, we will have time for a Q&A session. All questions pertinent to the webinar should be submitted via the chat function which we will enable, and we ask that you wait until after the presentation to submit your questions. For questions on topics not discussed during this webinar or that are specific to individual claims, you are advised to contact your Medicare Administrative Contractor, or MAC. You can find your MAC on the CMS website link at Review Contractor Directory – Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
By the end of this webinar, you should have a general understanding of non-invasive vascular studies, as well as how the data was analyzed. You should also be able to locate policy references and resources. If you did not receive a CBR in the mail or via fax, you may download a copy from our website page at CBR201604 Sample CBR (http://www.cbrinfo.net/cbr201604sample-cbr.html). A sample CBR is produced for each topic, and you may find it beneficial to have a copy of a CBR available to reference during the webinar. A CBR provides comparative data on how an individual health care provider’s billing and payment patterns for specific services compare to those of their peers. This particular CBR was created to inform providers about their billing and payment patterns for non-invasive vascular studies compared to their peers within their state and the nation.

The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules and to improve the level of care that they provide their Medicare patients. The CBR is solely for provider information. CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance.

**CBR FOCUS**

CBR201604 focuses on rendering providers of all specialties, excluding radiologists, who submitted claims for non-invasive vascular studies using CPT® codes 93880, 93882, 93925, 93926, 93970 and 93971. This report examines the average allowed services per beneficiary for the one-year period and the percentage of consecutive services.

**DEMOGRAPHICS**

The reports were sent to approximately 3,900 Medicare providers who rendered services for non-invasive vascular studies. These providers were selected by an analysis of data from claims paid by traditional Fee-for-Service Medicare that identified them as having different billing patterns when compared to their peers. The Methods & Results portion of this presentation will provide you with more information on the statistical analysis and the provider selection process.
WEBINAR MATERIALS

Links to all of the references and resources provided in the CBR and discussed today are currently available on the CBR website at CBR201604 Recommended Links (http://www.cbrinfo.net/cbr201604-recommended-links.html). Also, for your convenience, within five business days of today (April 13, 2016), we will be posting both a downloadable version of the webinar slides and a recording of the webinar presentation to our website. The slides are an outline only and do not contain any audio or speaker notes. The recording contains both the audio, as well as the video of the entire webinar. Additionally, all questions answered today, as well as applicable questions that we are not able to address this afternoon, will be answered and posted in a Q&A document. This will be posted to our website along with a handout of the presentation within two weeks of today. The webinar slides, recording, handout, and Q&A document will all be posted, when available, on the website page at CBR201604 Webinar Information (http://www.cbrinfo.net/cbr201604-webinar.html).

Please note that these are some of the acronyms that we will be using today:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETOS</td>
<td>Berenson-Eggers Type of Service</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
</tr>
<tr>
<td>NIVS</td>
<td>Non-Invasive Vascular Studies</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
</tbody>
</table>

Now that you have some information on the purpose, objective, and focus of this CBR, we would like to get your response to our second poll question.
POLL QUESTION

How do you plan to use the information in the CBR and the information presented today?

- To better understand Medicare guidelines for non-invasive vascular studies
- To educate our billing staff
- To locate references and resources
- To better comprehend CBR201604
- All of the above

Now that we have all of your answers, we will continue with our presentation. Thank you for your participation. And now, I will be turning it over to Cyndi Wellborn who will discuss the coverage and documentation overview.

COVERAGE & DOCUMENTATION OVERVIEW

Thank you, Molly. My name is Cyndi Wellborn, and I am a Registered Nurse with Palmetto GBA. My primary responsibility involves researching policies and billing guidelines for our CBR letters and webinar presentations. Today, we’ll be talking about non-invasive vascular studies.

TOPIC SELECTION

We get ideas for our reports by reviewing reports from other agencies and keeping up-to-date with current news and MAC audits. According to a July, 2009 Office of Inspector General (OIG) report, 20 high-use counties accounted for 16 percent of spending on ultrasound services, despite having only six percent of Medicare beneficiaries living in those counties.

<table>
<thead>
<tr>
<th>Topic Selection - OIG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office of Inspector General (OIG)</strong></td>
</tr>
<tr>
<td>- <em>Medicare Part B Billing for Ultrasound, OEI 01-08-00100, July 2009</em></td>
</tr>
<tr>
<td><strong>Comprehensive Error Rate Testing (CERT)</strong></td>
</tr>
<tr>
<td>- BETOS I3F Echography/ultrasonography other: <strong>16%</strong></td>
</tr>
<tr>
<td>- BETOS I3D Echography/ultrasonography carotid arteries: <strong>22%</strong></td>
</tr>
</tbody>
</table>
The OIG found that average spending per beneficiary on ultrasound in high-use counties was more than three times what was spent on beneficiaries residing in other parts of the country. For services rendered in 2007, Part B spent an average of $171 on ultrasound services for every beneficiary in the high-use counties compared to $55 elsewhere. To review the OIG report, select the following link: **Medicare Part B Billing for Ultrasound** ([http://oig.hhs.gov/oei/reports/oei-01-08-00100.pdf](http://oig.hhs.gov/oei/reports/oei-01-08-00100.pdf)).

*The Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payments Report* shows error rates by Berenson-Eggers Type of Service (BETOS) categories. Echography/ultrasonography – other (BETOS category I3F) had an error rate of 16 percent, with 100 percent of the errors due to insufficient documentation. One-hundred thirty-seven claims were chosen for review, and the improper payment amount for those codes was estimated to be $105 million. The codes included in BETOS category I3F are CPT® codes 93925, 93926, 93970 and 93971. Echography/ultrasonography of the carotid arteries (BETOS category I3D) had an error rate of 22 percent based on 82 claims sampled. The projected improper payment amount for those services was over $46 million. CPT® codes 93880 and 93882 are included in BETOS category I3D. For additional information, refer to the CMS web page at [The Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payments Report](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2014ImproperPaymentsReport.pdf?agree=yes&next=Accept). For detailed BETOS information, refer to the following web link: **Berenson-Eggers Type of Service (BETOS) Codes** ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeForSvcPartsAB/downloads/betosdescodes.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeForSvcPartsAB/downloads/betosdescodes.pdf).

**NEWS WORTHY FRAUD**

While most Medicare providers are legitimate and provide valuable services to each patient, which is not the case for everyone in the healthcare business. Some providers have made news headlines. In the first story, a Tampa Bay, Florida physician billed for unnecessary vein injections and ultrasound imaging procedures. The physician entered into a three-year, corporate integrity agreement with the OIG in order to remain in the Medicare program. That story can be viewed on the [Tampa Bay Times website](http://www.tampabay.com/news/courts/civil/bay-area-doctor-to-pay-400000-to-settle-medicare-billing-claims/2159981).

---

**“News”-worthy Fraud**

- **Tampa Bay doctor to pay $400,000 to settle Medicare fraud case**, The Tampa Bay Times, January 2014
- **Twenty-Three Defendants – Including Nine Doctors – Charged with Enterprise Corruption in Massive $7 Million Medicaid Fraud**, The Brooklyn District Attorney’s Office, March 2015
To review the OIG agreement, see the following link: INTEGRITY AGREEMENT BETWEEN THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND RAVI SHARMA, M.D. (http://oig.hhs.gov/fraud/cia/agreements/Ravi_Sharma_12132013.pdf).

In the second case, recruiters sent patients for unnecessary vein or artery tests performed by one of four podiatrists. The podiatrists fabricated symptoms and created false diagnoses in order to be paid. Three other physicians, a vascular surgeon and two cardiologists, then billed Medicaid and other insurance carriers, including Medicare, for medical services they did not perform or for reviewing the medically unnecessary vein and artery ultrasounds. For details about that case, see the Brooklyn District Attorney’s Office website link at Twenty-Three Defendants-Including Nine Doctors-Charges With Enterprise Corruption in Massive $7 Million Medicaid Fraud (http://brooklynda.org/2015/03/31/twenty-three-defendants-including-nine-doctors-charged-with-enterprise-corruption-in-massive-7-million-medicaid-fraud/).

At this point in the presentation, I’d like to stress that CBR reports have nothing to do with fraud. No medical records were reviewed as part of our process, and no overpayments have been identified. The CBR team is aware that practice patterns differ for various reasons, including geographic location and patient acuity levels. Some practitioners have sub-specialties and distinctive focuses that aren’t apparent in the claims data. Other providers practice in rural or under-served urban areas and may see a higher proportion of illness in Medicare beneficiaries. If those sound like characteristics of your practice, the results of the CBR letter may not be surprising. If, on the other hand, your CBR shows your utilization differs significantly from your peers, and you don’t know why that would be the case, you may want to choose a few charts that are representative of your normal utilization and perform a self-audit using the information that we present today. To get a better understanding of the self-auditing process, visit the CBR web page at Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

**MEDICAL REVIEW FOCUS AREAS**

Another way we get ideas for our topics is to review MAC websites to see what areas they are investigating. The medical review department of National Government Services (NGS) has reviewed Part B claims with more than one of the CPT® codes in our CBR that were billed on the same date of service for the same patient.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>On the Same Date of Service as CPT® Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>93880/93882</td>
<td>93970, 93971, 93925, and/or 93926</td>
</tr>
<tr>
<td>93925/93926</td>
<td>93880, 93882, 93970, and/or 93971</td>
</tr>
<tr>
<td>93970/93971</td>
<td>93880, 93882, 93925, and/or 93926</td>
</tr>
</tbody>
</table>
NGS started looking at these codes after identifying a large number of claims being billed for both arterial and venous studies on the same date of service. We’ll discuss the results of those audits in a few minutes. To view these findings, search for the review titled, “Medical Review Focus Areas - Prepayment Review Results: Vascular Studies for January, February and March, 2015” on the following NGS website: [NGS website link]

**CODE DESCRIPTIONS**

The CPT® codes included in the NGS focused review are all duplex scanning services. According to the CPT® Manual, “Duplex scan describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real-time images integrating B-mode two-dimensional vascular structure, Doppler spectral analysis, and color flow Doppler imaging.” CPT® code 93880 describes a complete bilateral study of the extracranial arteries while CPT® code 93882 describes a unilateral or limited study. CPT® codes 93925 and 93926 are used for studies of the lower extremity arteries, a complete bilateral and unilateral or limited respectively. CPT® codes 93970 and 93971 are billed for studies of extremity veins. CPT® 93970 is a complete bilateral study while CPT® 93971 describes a unilateral or limited study. In order to use the complete bilateral study codes, a complete exam must be done. The unilateral or limited study codes are used even when both extremities are studied when the exam is limited to one or two levels.

The CPT® Manual describes the difference between a limited and complete study of the upper and lower extremities in the header information found under Noninvasive Vascular Diagnostic Studies. Lower extremity studies are considered limited if they are performed at one or two levels with potential levels including high thigh, low thigh, calf, ankle, metatarsal and toes. Complete studies normally require measurements at three or more levels. For the upper extremities, limited studies also involve measurement at one or two levels with potential levels including arm, forearm, wrist, and digits. Likewise, a complete study normally requires...
measurements at three or more levels. Please refer to the CPT® Manual for a comprehensive description of complete and limited studies.

**DUPLEX ULTRASOUND**

The description of duplex ultrasound on this slide came from the American College of Radiology ACR Radiology Coding Source™ (January-February 2007), which states, “Duplex ultrasound combines Doppler and conventional ultrasound, allowing the radiologist to see the structure of blood vessels, how the blood is flowing through the vessels, and whether there is any obstruction in the vessels. Color Doppler produces a picture of the blood vessel, and a computer converts the Doppler sounds into colors overlaid on the image, representing information about the speed and direction of blood flow. Using spectral Doppler analysis, the duplex scan images provide anatomic and hemodynamic information, identifying the presence of any stenosis or plaque in the vessels.” The entire article can be viewed on the American College of Radiology (ACR) webpage at Noninvasive Vascular Diagnostic Studies (http://www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2007/Jan-Feb-2007/Noninvasive-Vascular-Diagnostic-Studies).
FOCUS AREA RESULTS - NGS

The reason that NGS gave for the focused medical review was the identification of a large volume of claims being submitted for arterial and venous studies for the same patient on the same date of service. The NGS website notes these results were based on the completion of the review for jurisdiction K which includes Connecticut, Illinois, New York, Maine, Massachusetts, Minnesota, New Hampshire, Rhode Island, Vermont and Wisconsin. The percentage of claims reduced or denied each month ranged from 74 percent to 76 percent. The first reason claims were reduced or denied was for failure of the documentation to meet the requirements of the LCD L27355, specifically lack of clinical indications to support the medical necessity of the study. Of course, LCD L27355 is now retired (effective October 1, 2015) due to the transition to ICD-10 and has been replaced with LCD L33627. Molly will provide you with a list of all the active LCDs that pertain to this topic at the end of the presentation.

MEDICAL REVIEW

Claims were denied because the documentation was vague regarding why the study was ordered. Documentation of edema, pain, or claudication, for example, should include the location and a description of the issue to include signs, symptoms, and severity. Those items are normally found in the progress notes in the history of present illness portion of the medical record.
NGS counted claims in error when the reason for the test was a provisional diagnosis instead of specific clinical indications. The diagnoses on the claim must relate to known diseases or abnormal signs or symptoms in order to support the necessity of the service. In some cases, NGS found that the documentation supported unilateral studies but not bilateral studies billed. In those cases, the claims weren’t denied. They were reduced to allow payments for unilateral studies.

**MEDICAL REVIEW (CONT)**

In some cases, the medical record failed to indicate that the patient was being seen due to post-operative complications, or that the patient had undergone prior vascular studies or surgery. Contradictory documentation is a problem noted occasionally in electronic health records, as practitioners copy information from prior dates of service or other patients’ records to use as templates to be inserted in other records during comparable encounters. Providers should ensure that all notes pertaining to the beneficiary are consistent with the reason given for the test. NGS cited examples of letters being submitted for purposes of supporting medical necessity without actually providing the radiology reports that would prove the services had been rendered as billed. To see these findings, search for the review titled, “Medical Review Focus Areas - Prepayment Review Results: Vascular Studies for January, February and March, 2015” on the following NGS website page:

[https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/entry/ut/p/a1/04_Sj9CPykssy0xPLMnMz0vMAfGjz0JNHD1dDQ2dDbzvTxND8xN XAKDHH1DD52MjYEKloEKDHAARwNC-sP1o1CV-8v7WwCvUdm5uAQGGLs7UGEV4LGiiDFCINNRUREAsE8b8g!!/dl5/d5/L2dBI5eZ0FBIS9nQSEh/](https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/entry/ut/p/a1/04_Sj9CPykssy0xPLMnMz0vMAfGjz0JNHD1dDQ2dDbzvTxND8xN XAKDHH1DD52MjYEKloEKDHAARwNC-sP1o1CV-8v7WwCvUdm5uAQGGLs7UGEV4LGiiDFCINNRUREAsE8b8g!!/dl5/d5/L2dBI5eZ0FBIS9nQSEh/)
OTHER DENIAL REASONS

These denial reasons were taken from NGS prepayment review results of vascular studies for January through March 2015. Signatures can be handwritten or electronic, but they must be legible. Stamp signatures are not acceptable. Claims were denied when providers did not submit medical records in response to the additional development/documentation request, or ADR. Providers have a limited amount of time to respond to these requests, as claims are set to automatically deny if a response is not received timely. NGS allows a 30-day development period for ADRs from the claims area and a 45-day window for ADRs from the medical review area. The ADR letter you receive will indicate the number of days you have to respond. To help providers determine the target date that the medical records must be received, NGS provides a calculator on its website at Additional Development/Documentation Request Timeline Calculator

During the review process, NGS received medical records that were not related to the procedure codes billed. Before submitting records to the MAC or the Comprehensive Error Rate Testing (CERT) contractor, providers should check to be sure that records support the claim the auditor is investigating. Claims were denied when the medical record had missing or incomplete beneficiary information. It is important to have the name of the beneficiary on every page of the medical record, along with the date of service because that’s where auditors start. Finally, in some cases, the rendering provider submitted on the claim form was not the physician who performed the service, based on the documentation submitted. To access the article, search for the review titled, “Medical Review Focus Areas - Prepayment Review Results: Vascular Studies for January, February and March, 2015” on the NGS website at

https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/entry/lut/p/a1/04_Sj9CPykssy0xPPLnMz0vMA0Gj0JNH0dDQ2d0bxw0wM0jOm100c3ccRDCx3GFLuUJFvAb_wElU2LOB=Part%20B&CONTRACTYPE=Title+XVIII+Providers?LOB=Part%20B&LOC=New%20Hampshire&ngsLOC=New%20Hampshire&ngsLOB=Part%20B&jurisdiction=Jurisdiction%20K

https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/entry/lut/p/a1/04_Sj9CPykssy0xPPLnMz0vMA0Gj0JNH0dDQ2d0bxw0wM0jOm100c3ccRDCx3GFLuUJFvAb_wElU2LOB=Part%20B&CONTRACTYPE=Title+XVIII+Providers?LOB=Part%20B&LOC=New%20Hampshire&ngsLOC=New%20Hampshire&ngsLOB=Part%20B&jurisdiction=Jurisdiction%20K
INDICATIONS 93880/93882

Some contractors like First Coast Service Options (FCSO) and Noridian cover the codes in our CBR with three separate documents, while CGS and National Government Services have one document covering all the codes in this CBR, as well as some other codes that we didn’t evaluate. Indications for carotid duplex studies that are common among all the MACs include bruits, recent strokes, carotid stenosis, neck trauma, suspected dissection and post carotid endarterectomy monitoring among many others. FCSO’s LCD L33695 (Non-invasive Extracranial Arterial Studies) states, “Non-invasive vascular studies are medically necessary only if the outcome will potentially impact the clinical management of the patient. Services are deemed medically necessary when all of the following conditions are met:

1) Significant signs/symptoms of ischemia are present;
2) The information is necessary for appropriate medical and/or surgical management; and
3) The test is not redundant of other diagnostic procedures that must be performed.”

The document gives the example of an asymptomatic carotid bruit. While it would be necessary to evaluate it upon initial finding, it would not be medically necessary to repeat this test when there is no evidence of carotid stenosis.

Several documents include frequency recommendations for follow up studies. In patients with known carotid stenosis, extracranial arterial studies are normally performed on an annual basis when the patient has a diameter reduction of between 20 and 50 percent. Diameter reductions of greater than 50 percent are normally followed every six months. Carotid studies can be used to determine the cause of a stroke in patients whose stroke occurred within six months of the test. When monitoring patients who have undergone carotid endarterectomy, duplex ultrasonography on the affected side is typically performed at six weeks, six months and one year after the procedure and then annually. Additional information can be found by selecting this link: [LCD L33695-Non-invasive Extracranial Arterial Studies](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33695&ver=4&Date=10%2f02%2f2015&DocId=L33695&bc=AAAAAgACAAAA%3d%3d&).
LIMITATIONS 93880/93882

LCD L35397 from Novitas Solutions states, “Non-invasive vascular studies will be considered not medically reasonable and necessary if the study results will have no impact on the decision for further diagnostic or therapeutic procedures. For example, if it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then non-invasive vascular studies are not necessary.”

First Coast Service Options’ LCD L33695 states, “When reporting syncope as an indication for this service, it is necessary to document that other, more common causes have been ruled out.”

LCD L35753 from Wisconsin Physicians Service Insurance Corporation states, “If an echocardiogram is negative for cardiac or cardiac valvular cause, it may be medically appropriate to perform extracranial arteries studies for the drop attack or syncope.”

To review more details about the above LCDs, refer to the website pages below:


---

**Page 16 of 37**
INDICATIONS 93925/93926

The indications listed here were taken from Noridian’s LCD L34219 titled, Noninvasive Peripheral Arterial Studies. Indications include, but are not limited to, lifestyle limiting claudication, rest pains usually associated with diminished or absent pulses, tissue loss defined as gangrene or pre-gangrenous changes, ischemic ulcerations occurring with diminished or absent pulses, aneurysmal disease, as well as follow-up studies in the post-operative period. Some of the LCDs include utilization guidelines for the frequency of follow-up studies. The Noridian LCD document is available for review on the CMS Medicare Coverage Database at [LCD L34219](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34219&ver=5&DocID=L34219&bc=gAAAAAgAAAAAAA%3d%3d&).

LIMITATIONS 93925/93926

The LCDs from Noridian Healthcare Solutions, First Coast Service Options, CGS Administrators and National Government Services include a statement to the effect that a routine history and physical, which includes ankle brachial indices (ABIs), can readily document the presence or absence of ischemic disease in a majority of cases. These LCDs state, “It is not reasonable and necessary to proceed beyond the physical examination for minor signs and symptoms unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention.”
Some examples considered to be minor signs and symptoms include hair loss, shiny thin skin, the absence of a single pulse without other signs and/or symptoms, relative coolness of the foot, and the lack of toenail growth. Most LCDs give some examples of signs and symptoms that don’t support medical necessity for arterial studies. Continuous burning of the feet is considered to be a neurologic symptom, for example. Some non-specific diagnoses like leg pain or pain in limb are too general to warrant testing unless other signs and symptoms are present. To find coverage guidance for these LCDs, select the below links:


**INDICATIONS 93970/93971**

Noridian’s LCD L34229 lists 791 ICD-10 CM codes that can be used individually and another 202 ICD-10 CM codes that can be used in combination with another ICD-10 code to support the medical necessity of peripheral venous studies. The document states that the indications for venous examinations are separated into four major categories, which include deep vein thrombosis (DVT), chronic venous insufficiency, and evaluation of pre-procedural and post-procedural venous conditions. Studies are reasonable and necessary only if the patient can be a candidate for anticoagulation, thrombolysis or invasive therapeutic procedures. Venous examinations are warranted in patients with clinical signs and symptoms of DVT or pulmonary embolism (PE) when they are candidates for anticoagulation or invasive therapeutic procedures. Unexplained, lower extremity edema following a major surgical procedure is a common reason for testing, because DVT frequently occurs in hospitalized patients due to prolonged immobility. We’ll discuss bilateral limb edema on the next slide. According to LCD L34229, chronic venous insufficiency
can also be divided into four categories which include primary varicose veins, secondary varicose veins, post-thrombotic syndrome and recurrent DVT. Venous studies are used when testing is indicated due to skin ulcerations, discoloration and/or thickening that is thought to be a result of venous insufficiency. The LCD states, “When the evaluation, management and treatment of the varicose vein are considered to be cosmetic only, billing for these services will be denied as cosmetic.” Venous studies may be covered when patients are being evaluated for creation of an arteriovenous (AV) fistula or prior to vein harvesting for bypass surgery. In regards to post-procedural studies, the determination states, “Duplex scan for post-interventional follow-up studies are typically limited in scope, and are unilateral in nature. Consequently, the complete duplex scan codes (93970) should seldom be used in the post-interventional setting.”

Guidance on coverage can be found on the website page at Noridian Healthcare LCD L34229 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34229&ver=12&Date=01%2f01%2f2016&DocID=L34229&bc=iAAAAAgAAAAAAA%3d%3d&).

**LIMITATIONS**

LCD L33627 from NGS repeats the statement that non-invasive vascular studies are considered medically necessary only if the outcome of the study will potentially impact the clinical course of the patient. The example they provided states, “If a patient is (or is not) proceeding on to other diagnostic and/or therapeutic procedures regardless of the outcome of non-invasive studies, and non-invasive vascular procedures will not provide any unique diagnostic information that would impact patient management, then the non-invasive procedures are not medically necessary.” Five LCDs covering duplex scans of the extremity veins state that it is rarely necessary to perform a study due to bilateral limb edema in the presence of signs and/or symptoms of congestive heart failure, exogenous obesity and/or arthritis. To view more information, select the following link: NGS LCD L33627 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33627&ver=35&Date=10%2f02%2f2015&DocID=L33627&bc=iAAAAAgACAAAAA%3d%3d&).
LIMITATIONS ALL CODES

The first limitation on this slide comes directly from the CPT® Manual and can be found in the header section for Noninvasive Vascular Diagnostic Studies. The use of a Doppler device that does not produce hard copy output or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported. LCD L33667 from First Coast Service Options adds further detail saying, “The appropriate assignment of a CPT® code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. If an examination is performed with hand-carried equipment, the quality of the exam, printout, and report must be in keeping with accepted national standards.” Zero-crossers are mentioned frequently as being included in the office visit.

Medicare does not cover routine screening tests. LCD L35451 from Novitas Solutions includes a diagnosis code to assign to the claim in the case of screening services. ICD-10-CM code Z13.9 will result in denial of claims as non-covered screening services. LCD L33627 from NGS states, “A referral for one non-invasive study is not a blanket referral for all studies. A referral must be on record for each non-invasive study performed.” More information about these LCDs is available on the CMS website pages below:

MORE LIMITATIONS

Several documents refer to arterial and venous studies on the same day and state that these tests should rarely be done during the same encounter. When arterial and venous studies are performed on the same date of service, the medical record must support the need for both studies. All six of the MACs with local coverage determinations covering duplex scanning of lower extremity arteries or arterial bypass grafts do not allow ABIs to be billed separately when they are performed without other vascular studies. LCD L33627 from NGS states, “An ABI is not a reimbursable procedure by itself; rather, ABI may be reimbursed when derived from a more comprehensive procedure which includes a permanent chart copy of the measured pressures and waveforms in the examined vessels. An ABI should be abnormal, e.g., < 0.9 at rest, and must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severe diabetes or uremia resulting in medial calcification as demonstrated by artifactually elevated ankle blood pressure.”

Some testing methods that are not acceptable for carotid or peripheral arterial studies include thermography, mechanical oscillometry, inductance, capacitance and photoelectric plethysmography and light reflection rheography. According to LCD L35397 from Novitas Solutions, “Carotid phonoangiography and other forms of bruit analysis are covered services, but are included in the reimbursement for the office visit.” The billing and coding guidelines document attached to LCD L35761 from WPS mentions the methods listed stating they “have not yet reached a level of development such as to allow their routine use in the evaluation of suspected peripheral vascular disease and are not covered since they are considered experimental.” National Coverage Determination 220.11 indicates that thermography has been non-covered for all indications since 1992. The LCDs mentioned can be accessed from the websites below:

That concludes the coverage and documentation overview portion of our webinar. And now we’ll have our third poll question.

**POLL QUESTION**

From the information presented today, do you have a better understanding of the coverage and documentation requirements for non-invasive vascular studies? Your answer options are:

- Yes
- Neutral
- No

And now, I’ll be turning the presentation over to Craig DeFelice who will go over the Methods & Results portion of our presentation.

**METHODS & RESULTS**

Good afternoon. My name is Craig Defelice. I am a Statistical Analyst with Palmetto GBA. I will be explaining the data, statistical analysis, and tables provided in this CBR.

**REPORT DATA**

This CBR focuses on non-invasive vascular studies. Individualized reports were sent to about 3,900 fee-for-service Medicare Part B providers. These providers were identified by NPI as submitted on the claim as **rendering NPI**. Claims were pulled for the CPT® codes listed here on the slide. For the
purposes of our analyses, we did not pull claim lines with a specialty of diagnostic radiology (specialty 30). Furthermore, to assure services were not counted twice in the analysis, only claims billed either globally (neither modifier 26 nor TC on the claim) or with the professional component (only modifier 26 on the claim) were kept for analysis. Claims billed with the technical component (only modifier TC on the claim) were removed from the analysis.

**PEER GROUP**

Each report contains the provider’s billing history and patterns and compares them to his/her peers. These comparisons are given so that each provider is aware of where he/she stands among peers and to allow him/her to see how his/her billing is different from peers. For this CBR, each provider is compared to two peer groups:

- **STATE** peer group is defined as all Medicare providers located in the provider’s state (as determined by NPPES) with allowed charges for the CPT® codes covered in this CBR.
- **NATIONAL** peer group is defined as all Medicare providers in the nation with allowed charges for the CPT® codes covered in this CBR.

**DATA SOURCE**

The data was extracted from the CMS Integrated Data Repository (IDR). We pulled the latest version of claims, as of January 19, 2016. The data includes claims with dates of service between October 1, 2014 and September 30, 2015. For additional information on the IDR, please visit the CMS website link titled, CMS Integrated Data Repository (IDR) ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html?redirect=/IDR](https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html?redirect=/IDR)).

**TABLE 1**

Table 1 is a Summary of Your Utilization of CPT® codes used in this CBR. The first column lists the CPT® codes included in this analysis, the second column, named Description, provides a short description of the CPT® code. Finally, the last 4 columns provide the total Allowed Charges, Allowed Services, Consecutive Services, and distinct Beneficiary Count for each CPT® code.

![Table 1](image)
**TABLE 1 - CPT® CODE SUMMARIES**

For example, under the CPT® column, the row for CPT® code 93925. It is described as **Duplex scan of lower extremity arteries, complete/bilateral**. The total allowed charges for those claim lines is $102,592.23. The total number of allowed services is 492, with 93 of those services flagged as consecutive, and a total of 484 distinct beneficiaries. This table also includes a total row, which summarizes the utilization of all codes. Due to the fact that some beneficiaries may be on multiple claims with different CPT® codes, the total for the beneficiary count may be less than the sum of the rows.

**COMPARISON OUTCOMES**

There are four possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** is displayed if the provider’s value is higher than the value of the peer group and the statistical test used confirms significance.
- **Higher** is displayed if the provider’s value is higher than the value of the peer group, but the statistical test does not confirm significance.
- **Does Not Exceed** is displayed if the provider’s value is not higher than the value of the peer group.
- **N/A (not applicable)** is displayed if the provider did not have data for comparison.

**AVERAGE ALLOWED SERVICES**

The first analysis is the average allowed services per beneficiary. It is calculated as the **Total Allowed Services** divided by the **Total Number of Beneficiaries**. Each provider’s average is compared to his/her state and the nation, using the t-test at the alpha value of 0.05.
**TABLE 2**

Table 2 is an example of the **Average Allowed Services per Beneficiary** analysis. In this example, this provider’s average allowed services were 1.19. His/her state’s average is 1.22, and the national average allowed services is 1.23. This provider’s average **Does Not Exceed** either his/her state’s average or the national average allowed services per beneficiary.

I’d like to walk through how the provider’s average allowed services per beneficiary was calculated using the data provided in Table 1.

**AVERAGE ALLOWED SERVICES PER BENEFICIARY (CONT.)**

The 1.19 we saw on Table 2 can be calculated as the **Total Allowed Services** divided by the **Total Number of Beneficiaries**. The total allowed services can be found by finding the **Total** row under **Allowed Services**, indicated by the red arrow on the left. This is 2482. The total number of beneficiaries can be found by looking at the **Total** row’s **Beneficiary Count**, the red arrow on the right, or 2090 beneficiaries.
CALCULATING AVERAGE ALLOWED SERVICES PER BENEFICIARY

Taking the 2482 services as the numerator and the 2090 beneficiaries as the denominator, we get 2482 divided by 2090, for approximately 1.19.

PERCENTAGE OF CONSECUTIVE SERVICES

The final analysis is the Percentage of Consecutive Services. Consecutive services are identified as services billed within 24 hours of another non-invasive vascular study. For example, if a provider renders a service for CPT® 93880 for a specific beneficiary and then bills a service for CPT® 93926 on the next day for the same beneficiary, then both services would be flagged. It is calculated as the Total Number of Consecutive Services divided by the Total Number of Services and then multiplied by 100. Each provider’s average is compared to his/her state and the nation using the chi-square test at the alpha value of 0.05.
TABLE 3

Table 3 is an example of the results of the Percentage of Consecutive Services analysis. This provider had 19 percent of his/her total services counted as a consecutive services. This was Significantly Higher than his/her state’s average of 4 percent and also Significantly Higher than the national average at 11 percent. Next, I’d like to walk through how the 19 percent was calculated using the data provided in Table 1.

PERCENTAGE OF CONSECUTIVE SERVICES (CONT.)

The 19 percent we saw on Table 3 can be calculated as the Total Number of Consecutive Services divided by the Total Number of Services. The total number of consecutive services can be found by looking at the total row’s Consecutive Services column, the red arrow on the right, or 472 services. The total Allowed Services can be found by finding the Total row under allowed services, indicated by the red arrow on the left. This is 2482.
CALCULATING PERCENTAGE OF CONSECUTIVE SERVICES

Taking the 472 consecutive services as the numerator, and the 2482 services as the denominator, we get 472 divided by 2482. We multiply by 100 to get approximately 19 percent. This concludes the Methods & Results portion of the CBR.

\[
\left( \frac{\text{Total Number of Consecutive Services}}{\text{Total Number of Services}} \right) \times 100 = \frac{472}{2482} = 19\%
\]

Before going back to Molly for References & Resources, we have another poll question:

**POLL QUESTION**

*Did the calculations help with understanding the CBR measures?*

- Yes
- Neutral
- No

Looks like most of your results are in. Here is Molly with references and resources.
REFERENCES & RESOURCES

Thank you, Craig. And now, I will review the references and resources that you may utilize to ensure that you are meeting Medicare guidelines for non-invasive vascular studies. As I mentioned previously, we provide links to all of the resources referenced in this webinar on our website page at CBR201604 Recommended Links (http://www.cbrinfo.net/cbr201604-recommended-links.html).

LCDS & LCAS

To start off, we have listed here the Local Coverage Determinations and Local Coverage Articles for these services published by various Medicare Administrative Contractors active on October 1, 2015 and those retired on September 30, 2015. To access these LCDs and LCAs on CMS’ Medicare Coverage Database, simply follow the link on this slide to the CBR website at CBR201604 Recommended Links (http://www.cbrinfo.net/cbr201604-recommended-links.html?wb48617274=1D8E9B06).

OFFICE OF INSPECTOR GENERAL (OIG)

Also, to choose our CBR topics, we look at reports by other agencies to find areas of vulnerability. We use OIG reports as a basis for our CBR reports because the investigations often support differences in billing patterns among providers. Listed below are OIG reports reviewed for our CBR presentation:

- Integrity Agreement, December 2013 (http://oig.hhs.gov/fraud/cia/agreements/Ravi_Sharma_12132013.pdf)
CMS

CMS resources that were reviewed in preparation of the webinar include the following:

- **The Supplementary Appendices Medicare Fee-for-Service 2014 Improper Payments Report**

- **Berenson-Eggers Type of Service (BETOS) Codes**

- **Comprehensive Error Rate Testing (CERT) Reports:**
  - **2012**
  - **2013**
  - **2014**

**MEDICARE MANUALS**

We also referenced the following Medicare manuals:

- **Medicare Claims Processing Manual, Chapter 12**

- **NCCI Policy Manual, Chapter I, Section 160.23**

**NEWS**

Also, as Cyndi mentioned, non-invasive vascular studies has made the news for being vulnerable for fraud within Medicare. Listed below are two articles previously discussed:

- **The Brooklyn District Attorney’s Office**
  - Twenty-three Defendants – Including Nine Doctors – Charged With Enterprise Corruption in Massive $7 Million Medicaid Fraud, March 31, 2015

- **Tampa Bay Times**
  - Tampa Bay Doctor to Pay $400,000 to settle Medicare Fraud Case, January 2014
ASSOCIATIONS

The CBR team also reviewed a report published by the American College of Radiology and the 2014 and 2015 editions of the CPT® Manuals. These references are available from the following links:

- **American Medical Association (AMA):** [https://commerce.ama-assn.org/store/](https://commerce.ama-assn.org/store/)
  - CPT® 2014 Professional Edition
  - CPT® 2015 Professional Edition

- **American College of Radiology (ACR):** [www.acr.org](http://www.acr.org)

ADDITIONAL RESOURCES

Additional resources include the National Government Services' Medical Review Focus Areas and title 18 of the Social Security Act, which delves into health insurance for the aged and disabled. To review more information, select the links below:

- **National Government Services:**
  - Medical Review Focus Areas - Prepayment Review Results: Vascular Studies for January, February and March 2015 ([https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/complianceandaudits/medical-review/medical-review-focus-areas/medical-review-focus-areas-detail/prepayment%20review%20results-vascular%20for%20january%20february%20and%20march%202015/lut/p/a1/VIllBlwLEpWwVX3prZOdZOCYK8VBCIlhC4qGb1xJvQOEH4D9hBlvVb9aog9gGx7p7jxSE47CAY7qfJfLoVfOrGh0BHomyPCAww_FJ-ZInW-12VSM5gZe4RCHNRxpXlb7lLYoziwK_Sdc4cb4d-DGYZ9EDISdUqThMc6BQKkMiiMcyYMSeupqgQakaQSpv7TVQpxkBLtsiWhYAaBOZawFhAI5MYyY8cdyme6WlqT1bH2fqlNL-SR80yjQHP5uNNeIXxyjyuCycfgauBu5kvHF-xO5Ah11xvwK3licdIP7U0fY_ZaA3-1ZsRkKdwfuVshCcS5SpvpV4XXFawTnnRYM4Pab0jK76kDW1d1q6PmTAUd0ckpTWiUcuUFxAH5-RxGvH0hKBUJf25CGyjjfOod2Grfo8707YN6L9HV13amvawSbpzqZ5G3NdEyFb81j/dIS/dS/L2dBI5eV20FbIS9nQSeh/7c1earcookie=&savecookie=&REGION=&LOB=Part%20B](https://ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/complianceandaudits/medical-review/medical-review-focus-areas/medical-review-focus-areas-detail/prepayment%20review%20results-vascular%20for%20january%20february%20and%20march%202015/lut/p/a1/VIllBlwLEpWwVX3prZOdZOCYK8VBCIlhC4qGb1xJvQOEH4D9hBlvVb9aog9gGx7p7jxSE47CAY7qfJfLoVfOrGh0BHomyPCAww_FJ-ZInW-12VSM5gZe4RCHNRxpXlb7lLYoziwK_Sdc4cb4d-DGYZ9EDISdUqThMc6BQKkMiiMcyYMSeupqgQakaQSpv7TVQpxkBLtsiWhYAaBOZawFhAI5MYyY8cdyme6WlqT1bH2fqlNL-SR80yjQHP5uNNeIXxyjyuCycfgauBu5kvHF-xO5Ah11xvwK3licdIP7U0fY_ZaA3-1ZsRkKdwfuVshCcS5SpvpV4XXFawTnnRYM4Pab0jK76kDW1d1q6PmTAUd0ckpTWiUcuUFxAH5-RxGvH0hKBUJf25CGyjjfOod2Grfo8707YN6L9HV13amvawSbpzqZ5G3NdEyFb81j/dIS/dS/L2dBI5eV20FbIS9nQSeh/7c1earcookie=&savecookie=&REGION=&LOB=Part%20B))
  - Social Security Administration:
    - Title XVIII of the Social Security Act: Section 1862 (a) (1) (A), Section 1862 (a) (7), Section 1833 (e) ([https://www.ssa.gov/OP_Home:ssact/title18/1800.htm](https://www.ssa.gov/OP_Home:ssact/title18/1800.htm))

CBR WEBSITE

In addition to the actual CBR, there are a number of resources available that will provide you with more information on the CBR program. Again, our website is [http://www.cbrinfo.net/](http://www.cbrinfo.net/).

The website includes a great deal of information for the provider and supplier community. On this site, you will find more information on:
• eGlobalTech and Palmetto GBA
• The most current CBR release as well as previous releases
• CBR support material that is created to give providers and suppliers various tools they can utilize when reading their CBRs
• Education information to include material on the most current CBR webinar as well as all previous outreach events
• Recommended Links
• Frequently Asked Questions
• And contact information for our help desk

**FAQS**

Our website has two distinct FAQ sections. The first, located at the link titled, [General CBR FAQs](http://www.cbrinfo.net/faqs.html), answers questions such as “**What is a CBR?**” and “**How do I update my address?**” Additional FAQ pages are provided for each CBR release. For example, on the CBR page link, [CBR201604 FAQ](http://www.cbrinfo.net/cbr201604-faqs.html), you will find questions and answers specific to this CBR, such as “**How are the peer groups defined?**” and “**How was the data obtained for this report?**”

Now that we’ve gone over the References & Resources for this CBR, we would like to invite you to participate in our last poll question.

**POLL QUESTION**

Do you feel the CBR provided educational benefit?

• Yes
• Neutral
• No
• Did not receive a CBR

It looks like we have gotten everyone’s responses. Thank you all for your participation.
PROVIDER SELF-AUDIT

After receiving a CBR, there are some additional steps that you may choose to take with this information in hand. For example, we encourage you to perform a self-audit. Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly. Self-audits help providers and suppliers identify coverage and coding errors. To aid in this effort, we recommend you use the Coverage and Documentation Overview and References sections discussed earlier and supplied in each CBR as a guide. If you need assistance with beginning the audit process, please visit our CBR website where you will find the link, Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

CBR SUPPORT HELP DESK

If you have any questions regarding the CBR program, we encourage you to contact us. The CBR Support Help Desk is available from 9:00 a.m. to 5:00 p.m. ET Monday through Friday. Listed here, we have the toll free number, which is 1-800-771-4430 and our email address is cbrsupport@eglobaltech.com. Both the telephone number and the email address are located on the actual CBR and the CBR website at http://www.cbrinfo.net/ for your convenience.

CONTACTING MACs

Providers should contact the MAC for their geographic areas for assistance with questions about specific claims, documentation requirements, and billing and coding questions. We encourage you to check with your MAC to ensure you are meeting the standards for all services that you are providing. MAC contact information is easily accessible on the CMS website at the link, Review Contractor Directory – Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

NPPES

eGlobalTech receives all contact information used in producing and disseminating the CBRs from the information providers and suppliers add to the National Plan and Provider Enumeration System, or NPPES. Fax is the default dissemination method; but if a provider does not have a fax number listed in the system or if more than five CBRs are scheduled to go to the same fax number, we mail the reports instead.

It is important to note that for each CBR release we have, there is always a percentage of reports that come back as undeliverable as addressed. It is imperative for providers to make sure their contact information is up-to-date in NPPES to ensure future CBRs and other CMS correspondence reach the provider.
The mailing address and fax number listed with each report are the ones on file in the NPPES system. If your CBR lists an incorrect address or was sent to an incorrect fax number, you are advised to update this information in NPPEs. This link is provided here, but we also have a link on the CBR website. The link to the CMS website is provided here at the link, NPPES (https://nppes.cms.hhs.gov/NPPES/Welcome.do). We also have a link on the CBR website at http://www.cbrinfo.net/.

QUESTIONS & ANSWERS

And now, we will be moving on to the Question & Answer (Q&A) portion of the Webinar. As I previously mentioned, you will be able to submit questions via the chat function that we will enable. Any questions related to the information presented that we are not able to respond to this afternoon will be addressed and posted in a detailed Q&A document which we will be posting to our website along with a handout of the presentation. They will be made available within 14 business days of today (April 13, 2016), and can be found on the CBR website on the page titled, CBR201604 Webinar Information (http://www.cbrinfo.net/cbr201604-webinar.html).

Lastly, please note that we make every effort to address all questions submitted during our webinars; however, we cannot provide responses related to coding issues or specific claims and scenarios. Since your MAC makes the determination to pay or deny a claim based on the CPT® codes, medical documentation, and description of the circumstances, and we do not have access to this documentation, we cannot respond to these types of questions. Please contact your MAC with questions that we do not address or if you identify any claims discrepancies while reviewing your CBR. Contact information for your MAC can be accessed from the CBR website at this link: CBR201604 Webinar Information (http://www.cbrinfo.net/cbr201604-webinar.html) or from the CMS website link at Review Contractor Directory – Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Tracking-Contractors/Contractor-Directory-Interactive-Map/).

Melanie, we are now ready to move on to the Q&A session. Thank you all for your time.
REFERENCE & RESOURCE WEB LINKS

The below reference and resource website links have been added to the webinar transcript of CBR201604: Non-invasive Vascular Studies to optimize your browsing experience while reading and/or listening to the webinar. All web links are accurate as of the date of the webinar (April 13, 2016), but may change due to frequent changes in Medicare policy or movement or change of online content by external publishers.

Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAAA%3d%3d%3d%3d&)

Questions and Answers Document (http://www.cbrinfo.net/assets/cbr201604-questions-and-answers.pdf)


CBR201604 Sample CBR page (http://www.cbrinfo.net/cbr201604-sample-cbr.html)

CBR201604 Recommended Links (http://www.cbrinfo.net/cbr201604-recommended-links.html)

CBR201604 Webinar Information (http://www.cbrinfo.net/cbr201604-webinar.html)

Medicare Part B Billing for Ultrasound (http://oig.hhs.gov/oei/reports/oei-01-08-00100.pdf)


Tampa Bay doctor to pay $400,000 to settle Medicare fraud case (http://www.tampabay.com/news/courts/civil/bay-area-doctor-to-pay-400000-to-settle-medicare-billing-claims/2159981)


Medical Review Focus Areas - Prepayment Review Results: Vascular Studies for January, February and March 2015

CGS Administrators LCD L34035
First Coast Service Options LCD L33695
First Coast Service Options LCD L33667
NGS LCD L33627
National Government Services LCD L33627
Noridian Healthcare LCD L34219
Noridian Healthcare LCD L34229
Novitas Solutions LCD L35397
Wisconsin Physician Services LCD L35753
WPS LCD L35761
NCD 220.11
CMS Integrated Data Repository (IDR)
Title XVIII of the Social Security Act: Section 1862 (a) (1) (A), Section 1862 (a) (7), Section 1833 (e)

NPPES