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INTRODUCTION

These questions are excerpted from the CBR201604: Non-invasive Vascular Studies webinar presented on Wednesday, April 13, 2016. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version, or view the webinar text. You may also open a PDF of the slides only or select a specific section of the webinar. All of these options are available from the CBR website page titled, CBR201604 Webinar Information (http://www.cbrinfo.net/cbr201604-webinar.html).

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 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), Local Coverage Articles (LCAs), and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled, Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&a=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAA%3d%3d&=).

Please refer any specific questions you may have to the MAC 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. A listing of all MACs can be accessed from the website of CMS at the following link: Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

GENERAL

Q. Do you provide CEUs?
A. The Centers for Medicare & Medicare Services (CMS) does not offer credit for attending a CBR webinar; however, please check with the AAPC to determine if the organization will award CEU credit for attending the webinar. CMS provides Information related to CEU credits on its
Q. What is a comparative billing report, as it pertains to this topic?
A. The purpose of a Comparative Billing Report (CBR) for this topic is to inform and educate providers about their billing and payment patterns for non-invasive vascular studies. CBR201604 focuses on duplex scans of the extracranial arteries, lower extremity arteries or extremity veins, billed by providers of all specialties except radiology. The report contains data-driven tables with an explanation of findings that compare providers’ billing and payment patterns to those of their peers in their state and across the nation. For more information about CBRs, please visit our website link titled, Comparative Billing Reports.

Q. Is a CBR an audit?
A. A CBR is not an audit or precursor to an audit. While CMS directs the activities of the CBR team, we do not review any medical records or identify any overpayments. The CBR can, however, assist providers with performing self-audits of their own procedures and billing practices. If you are interested in performing a self-audit of your claims, you may benefit from the material on our CBR website at the web link titled, Self-Audit Help.

Q. Have all of the CBRs been sent to the providers – and when were they sent?
A. All of the CBRs for this webinar have been sent to approximately 3,900 Medicare Part B providers who submitted claims with CPT® codes for non-invasive vascular studies and whose data was significantly higher than their peers in at least one of the measures in this CBR. The CBRs were sent on March 14, 2016. A mock provider’s CBR can be reviewed at the following link: CBR201604 Sample CBR.

Q. Can a provider request a CBR to reference?
A. The CBR team does not produce CBRs by request on an ad-hoc basis; however, a CBR Sample Letter is available as a reference on the CBR website. If you did not receive a CBR letter and wish to review a sample of a mock provider, please visit the CBR website at the following link: CBR201604 Sample CBR.

Q. How can I find out if a CBR letter was sent to one or all of our physicians?
A. If you have questions about a specific CBR, please contact the CBR Support Help Desk for information by telephone at 1-800-771-4430 or by email at cbrsupport@eglobaltech.com.

Q. Is this CBR specialty-specific, or is it for all providers?
A. 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 and 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 measures for this report include the average services per beneficiary for a one-year period and the percentage of consecutive services (billed within 24 hours of another service). If you did not receive a CBR letter and wish to review a sample of a mock provider, please visit the CBR website at the following link: CBR201604 Sample CBR (http://www.cbrinfo.net/cbr201604-sample-cbr.html).

Q. Is CBR201604 about comparing APC’s (ambulatory payment classifications) to CPT® codes?
A. No. The CBR team reviewed only Part B, Fee-for-Service Medicare (Original Medicare) claims of providers who billed for these services and did not include APCs in our analyses. CBR201604 focuses on providers of all specialties, excluding radiologists, who rendered services and submitted claims for non-invasive vascular studies using current procedural terminology (CPT®) codes 93880, 93882, 93925, 93926, 93970, and 93971. Non-invasive vascular studies were selected as a topic for CBR201604 because a recent study by National Government Services (NGS) identified a large number of claims for non-invasive vascular studies lacked the supporting documentation required by LCD L33627. Also, an investigation by the Office of Inspector General (OIG) found large variations in billing patterns for ultrasound services and determined ultrasound to be an area vulnerable to fraud, waste, and abuse. To review details of LCD L33627, see the following link: LCD L33627 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDid=33627&ver=33&Date=01%2f01%2f2016&DocID=L33627&bc=iAAAAAgAAAAAAA%3d%3d&). To review the OIG report, select the web link at Medicare Part B Billing For Ultrasound, OEI-01-00100, July 2009 (http://oig.hhs.gov/oei/reports/oei-01-08-00100.pdf).

Q. How would you suggest that providers do an audit?
A. The CBR team recommends that providers review representative samples of their medical records on a regular basis to ensure proper billing and payment procedures but does not make recommendations regarding the frequency of self-audits. Providers are encouraged to review resources for setting up an audit process that are available on our CBR website at the link titled, Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

Q. How soon can I print out a copy of this Webinar?
A. The CBR201604 slides are already on the CBR website located at the web link, CBR201604 Webinar (http://www.cbrinfo.net/cbr201604-webinar.html). The Q&A document and a detailed handout of the webinar will be available on the website within 14 days of the webinar date. Providers may also benefit from additional information available on our CBR website. Links to references and
resources are available on the CBR website at the following link: CBR201604 Recommended Links page (http://www.cbrinfo.net/cbr201604-recommended-links.html).

**CLINICAL & BILLING**

**Q. Will diagnostic codes be addressed in the webinar?**
A. No, diagnostic codes will not be addressed in the webinar. The webinar will address only general indications for coverage, as outlined in the local coverage determinations (LCDs) and will not go into an in depth discussion of covered diagnoses. Providers should review the LCD in place in their jurisdiction for a complete list of covered diagnoses for each CPT® code covered in the CBR. All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled, Medicare Coverage Database (http://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=gAAAAAAAAAAAA%3d%3d&a=&).

Please refer any specific questions you may have to the MAC 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. A listing of all MACs can be accessed from the website of CMS at the web link: Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Q. Do the same rules apply to patients seen in nursing homes with Part B coverage?**
A. Yes, if the patient’s stay is not covered by Medicare Part A, providers may bill Medicare Part B for noninvasive vascular studies. When the patient’s stay is covered by Medicare Part A, the facility is considered the responsible party when medically necessary services are furnished with some exceptions, such as certain computed axial tomography scans, certain magnetic resonance imaging services, and certain ambulatory services. For more information, see the Medicare Claims Processing Manual, Chapter 6, SNF Inpatient Part A Billing and SNF Consolidated Billing (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf).

**Q. With regards to the situation of a rendering provider on the claim form not being the same as the provider who performed the service: if a lab technician renders the service, which is then interpreted by a physician, shouldn’t that physician be considered the rendering provider and also sign that record?**
A. The final report should be interpreted and signed by a qualified physician. The CBR team did not review the medical records in question, so we are unable to say who signed them; we are
only able to say that it was not signed by the physician who billed for the service according to
the information provided by National Government Services. For a complete list of
denial/reduction reasons, please refer to the article titled, Prepayment Review Results:
Vascular Studies for January, February and March 2015

Q. Can a screening for AAA (abdominal aortic aneurysm) still be done? If so,
does it have to be ordered by the primary care doctor, or can the vascular
surgeon order it?
A. Yes, the screening for AAA can be ordered by either physician. Medicare Part B covers a one-
time abdominal aortic aneurysm ultrasound if the patient meets certain eligibility
requirements. According to CMS’ MLN Matters® MM5253 updated on December 5, 2014, “the
beneficiary only needs to obtain a referral from their physician, physician assistant, nurse
practitioner, or clinical nurse specialist.” The document also states that eligible beneficiaries
would have “at least one of the following risk categories:

1. Has a family history of abdominal aortic aneurysm;
2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
3. Is a beneficiary, who manifests other risk factors in a beneficiary category
   recommended for screening by the United States Preventive Task Force regarding AAA,
   as specified by the Secretary of Health and Human Services, through the national
   coverage determinations process....”

If the screening is provided in a physician office, the service is billed to the carrier using the
HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for
abdominal aortic aneurysm (AAA) screening.” For more information on these screening, please
select the following web link: Implementation of a One-Time Only Ultrasound Screening for
Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive
Physical Examination (https://www.cms.gov/outreach-and-education/medicare-learning-network-
mln/mlnmattersarticles/downloads/MM5235.pdf). While the CBR team did not find that a specific ICD-10
diagnosis code was required, Z13.6 describes an encounter for cardiovascular disorders
[abdominal aortic aneurysm (AAA)]. This service is covered once in a lifetime, and the
copayments and deductibles for this service are waived. For more information on preventive
services regarding ultrasound screening for abdominal aortic aneurysms (AAA), please see the
quick reference chart located at the following web link: Preventive Services
Q. Can arterial and venous studies be performed on the same date of service for inpatient, place of service (POS) 21?
A. The CBR team was unable to find any regulations which prevent physicians from performing arterial and venous studies on the same date of service in an inpatient setting, although some procedures may be subject to National Correct Coding Initiative edits or Outpatient Prospective Payment System packaging edits. Additional information can be found at the following web link, titled, **NCCI Policy Manual, Chapter 1**, (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=nationalcorrectcodinited/).

Q. What documentation and code (complete vs. limited) is needed when billing followup studies?
A. While the CBR team isn’t able to provide coding advice, a complete description of the requirements for complete and limited vascular studies can be located under the header information titled, “Noninvasive Vascular Diagnostic Studies” in the **CPT® Manual**, which can be located at the following web link: **American Medical Association** (https://commerce.ama-assn.org/store/). Limited studies generally involve one to two levels, while complete studies involve three or more levels. Limited studies can be performed bilaterally when the exam is limited in scope. **CPT®** states that potential levels for lower extremities include high thigh, low thigh, calf, ankle, metatarsal, and toes, while potential levels for upper extremities include arm, forearm, wrist and digits. National Government Services has an active Local Coverage Article (A52859) which states, “Duplex post-interventional follow-up studies are typically limited in scope and unilateral in nature. Consequently, the ‘complete’ duplex scan codes, e.g., 93925 or 93930, should seldom be used while the ‘unilateral or limited study’ codes, e.g., 93926 or 93931, should typically be used.” Documentation should include the relevant medical history, comparisons with prior studies if applicable, a description of the studies performed, retention of the ultrasound images, measurements and final interpretation. When studies are performed for post-procedural follow up, the medical record should include information about the procedure. To review more information about followup studies, select the following web link: **National Government Services A52859** (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33627&ver=35&Date=10%2f02%2f2015&DocId=L33627&bc=iAAAAAgAAAAAAA%3d%3d&).

Q. Where are the best references for documentation requirements for non-invasive vascular studies?
A. Direct links to the coverage and documentation guidelines, references, and resources are available on the CBR website page titled, **CBR201604 Recommended Links** (http://www.cbrinfo.net/cbr201604-recommended-links.html) page. If you have questions about billing, please select from the list of MACs that is located on the Centers for Medicare & Medicaid Services (CMS) website at the link titled, **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/).
METHODS & RESULTS

Q. Why are sub-specialties not taken into consideration for the CBR?
A. Provider sub-specialty data is not provided on the claims data and was unavailable for the analyses. Individualized reports were sent to about 3,900 fee-for-service Medicare Part B providers, who were identified by NPI on the claim as the “rendering NPI”. 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 globally (neither modifier 26 nor TC on the claim) or billed with the professional component (modifier 26 on the claim).

Q. In reference to Table 1, were vascular surgeons not included in the review?
A. Table 1 is titled, Summary of Your Utilization. The first column lists the CPT® codes included in this analysis. The second column titled, Description, provides a short explanation of each CPT® code. The last four columns provide the total Allowed Charges, Allowed Services, Consecutive Services and distinct Beneficiary Count for each CPT® code. Any provider who does not bill under a specialty of diagnostic radiology (specialty 30) with allowed services for the CPT® codes listed in Table 1 with dates of service from October 1, 2014 to September 30, 2015 was included in the review. To help illustrate Table 1, see the mock provider’s sample CBR at the link, CBR201604 Sample CBR (http://www.cbrinfo.net/assets/cbr201604-sample-cbr.pdf).

Q. Can you define “consecutive services” and give examples with CPT® codes?
A. For the purposes of CBR201604, “consecutive services” is defined as services billed within 24 hours of another non-invasive vascular study. Each service is flagged individually as a consecutive service, or not, by searching for a different visit on the day prior, the day of, or the day after. For example, if a provider rendered a service for CPT® code 93880 for a specific beneficiary on January 4th and then billed a service for CPT® code 93926 on January 5th for the same beneficiary, each of those services were identified as being “consecutive services.”

Q. Do “consecutive services” include E&M codes or only the codes included on this report?
A. For the purposes of this CBR, “consecutive services” do not include E&M codes; however, services were flagged if non-invasive vascular study codes were billed within 24 hours of the non-invasive vascular study CPT® codes included in this report.

Q. Why do you count both services as being “consecutive services” instead of just the second?
A. The **Percentage Consecutive Services** analysis was used to identify what percentage of a provider’s services is part of a series of consecutive services. By flagging all services, we get a sense of the proportion of a provider’s services within 24 hours of another non-invasive vascular study. In the end, both metrics measure a similar statistic. Furthermore, the same methods were used for each peer group, providing a useful comparison of the same metric to each of the provider’s peer groups. To view the percentages of consecutive services for all states and the nation, please select the following link: [CBR201604 Percentage of Consecutive Services.xls](http://www.cbrinfo.net/assets/cbr201604-percentage-of-consecutive-services.xls).

**Q. If ABI (ankle-brachial index) was performed on the same date as venous duplex, was it flagged as consecutive?**

A. No, the CBR team did not include procedures which include an ABI (CPT® codes 93922, 93923 or 93924) in our analyses. CPT® codes 93922, 93923 and 93924 include other procedures in addition to an ABI. For example, CPT® code 93922 could be paired an ABI with Doppler waveform recording, volume plethysmography, or transcutaneous oxygen tension measurement.

**Q. Use of ABIs in the Medicare population has an unsatisfactory rate of false negative readings due to arterial stiffness and hardening. Many patients end up referred for arterial duplex, which is beneficial. Can you clarify if ABI alone is reimbursable?**

A. According to LCD **L34219** from Noridian Healthcare Solutions, LLC states, “ABIs, as separate procedures, are not reimbursable. An abnormal ABI (i.e., <0.9 at rest) must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severe elevated ankle blood pressure.” LCD **L35761** from Wisconsin Physicians Service Insurance Corporation states, “Ankle-brachial index alone or when part of the physical examination, and not as part of the limited or complete bilateral physiological studies, is not separately covered.” To obtain additional information, select the web links titled, Noridian Healthcare Solutions’ [LCD L34219](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx? LCDId=34219&ver=S&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=peripheral&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&)](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx? LCDId=34219&ver=S&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=peripheral&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&]) and/or Wisconsin Physicians Service Insurance Corporation’s [LCD L35761](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx? LCDId=34219&ver=S&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=peripheral&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&]).

**Q. Can you explain the methodology for the average allowed service per beneficiary? It would seem the more allowed services, the higher the number; the fewer (denied) allowed services, the lower the number. It seems to be the opposite in this CBR.**
A. The calculation for the average allowed services per beneficiary analysis is, as follows: **Total Allowed Services** divided by the **Total Number of Beneficiaries**. The metric measures the total allowed non-invasive vascular studies received by each beneficiary on average. You are correct in assuming the more allowed services, the higher the metric or similarly the lower allowed services, the lower the metric. To view the average allowed charges per beneficiary for each state and the nation, please select the following link: [CBR201604 Average Allowed Services per Beneficiary.xls](http://www.cbrinfo.net/assets/cbr201604-average-allowed-services-per-beneficiary.xls).

**Q. What does it mean if Allowed Charges are found to be significant?**

A. If a CBR indicated that a provider’s allowed charges were **Significantly Higher** than his/her peers, it only indicates that the numbers are higher. This difference could be due to the fact that patients are seen more frequently or that a provider consistently bills higher level codes. However, there is no assumption of wrongdoing. Significance is determined by the results of the chi-square test or t-test, which involve calculations based on the total number of services and the variation of those services of each individual provider’s data. It is recommended, however, that providers consider reviews of medical records to ensure proper billing and payment procedures. For assistance with beginning a self-audit process, refer to the CBR website page at, [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).

**Q. On Table 2, average allowed services per beneficiary indicates that the provider is “significantly higher” – is this necessarily bad?**

A. A result of **Significantly Higher** implies that the provider has a higher average that is significant according to the results of the statistical test used when compared to peers. This does not necessarily mean that the provider is an “outlier.” It is important to remember that a provider may have valid reasons for billing higher than his/her peers. The intent of the CBR is to be informative and give providers information about where they stand among their peers. For more information about CBRs, please visit the CBR website at the web link titled, [Comparative Billing Reports](http://www.cbrinfo.net/index.html).

**Q. My allowed charges are higher than the national averages. Are my allowed charges being compared to providers in other states that have lower allowed charges?**

A. Medicare Physician Fee Schedule (MPFS) allowed amounts vary from area to area. While we understand that these differences may affect a provider’s average allowed charges per beneficiary, these comparisons are provided so that providers may get a better idea of where they stand in comparison to the nation, as a whole, and to providers in their states. If a provider knows that the area has higher allowed charges when compared to than the national average, then a higher average would not necessarily indicate any wrong-doing. A geographic practice cost index (GPCI) has been established to account for the variation in practice expenses across...
the states and nation. More information on the GPCI is available on the CMS website at the link, Documentation and Files - National Physician Fee Schedule and Relative Value Files.

**Q. CBR201606 focused on a comparison of studies per beneficiary but did not take into account the total number of patients an MD is seeing, correct?**

A. Correct. The CBR compares the amount of non-invasive vascular studies patients received on average, if they received at least one. More information on the statistical analysis of this CBR can be found at the web link titled, CBR201604 Statistical Debriefing ([http://www.cbrinfo.net/cbr201604-statistical-debriefing.html](http://www.cbrinfo.net/cbr201604-statistical-debriefing.html)).

**Q. I am one in a group of four cardiologists who is the only one in the group who reads all the ultrasound studies, so my ratios may look higher. How do you take this into account in the analyses?**

A. This factor is not taken into account in our analyses. It is important to remember that a provider may have valid reasons for billing higher than his/her peers. The intent of the CBR is to educational and to give providers information about where they stand amongst their peers.

**Q. Our office has six doctors with a very high volume of patients, not all of whom receive vascular studies. Do you take into consideration the total number of patients seen by the group when calculating the allowed number per physician? Do you calculate the allowed number for a group who is billing with the same tax ID#?**

A. The CBR compares the amount of non-invasive vascular studies patients receive on average, given they received at least one. The total number of patients seen has no bearing on this metric. We do not take into account different providers in a group billing with the same tax ID#. It is important to remember that a provider may have valid reasons for billing higher than their peers. The intent of the CBR is to be informative and give providers information about where they stand amongst their peers. Providers can find more information on the purpose of comparative billing reports at the web link titled, Comparative Billing Reports ([http://www.cbrinfo.net/index.html](http://www.cbrinfo.net/index.html)).

**Q. If a physician billed using a study with separate technical component (TC) modifier and separate professional component 26 modifier, were these types of services picked up in your review data capture?**

A. Services that were billed globally (neither modifier 26 or TC on the claim) or billed with the professional component (modifier 26 on the claim) were included in the analysis. This means that services billed using only the technical component (TC) modifier were dropped from the analysis. The intent was to avoid double counting related services.
Q. Why didn’t CPT® codes 93882 and 93926 have any information in Table 1?
A. The CPT® codes 93882 and 93926 within the sample had 0’s instead of values, indicating that our mock provider had no billings for those codes during the time frame analyzed.

Q. Can you restate the information about global, TC, PC codes in the analysis? Are split billed codes not included in the results?
A. Services that were billed globally (neither modifier 26 or TC on the claim) or billed with the professional component (modifier 26 on the claim) were included in the analysis. This means that services billed only using the technical component (TC) modifier were dropped from the analysis in order to avoid “double counting” related services.

Q. The state of Arizona does not have an LCD for non-invasive testing, so we followed the previous LCD that was retired. Which MAC policy should we be following?
A. The CBR team would suggest contacting your MAC for clarification. Noridian Healthcare Solutions published an article regarding the retired LCD which can be found at the website titled, [LCD Retirement Clarification](https://med.noridianmedicare.com/web/jeb/policies/lcd/retired/retirement-clarification). The document states, “LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretive manual or an article. Most LCDs are not retired because they are incorrect. The guidance in the retired LCD may be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in LCDs, they will want to be very careful in departing from these practices just because the LCD is retired.” The CBR team recommends that all providers with billing questions contact their respective MACs at the following web link: [Medicare Administrative Contractors (MACs)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACJurisdictions.html).
REFERENCES & RESOURCES

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

Medicare Coverage Database (http://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&bcg=AAAAAA%3d%3d&


Comparative Billing Reports (http://www.cbrinfo.net/index.html)

Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)

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


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


Preventive Services
(https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf)

NCCI Policy Manual, Chapter 1,

American Medical Association (https://commerce.ama-assn.org/store/)


CBR201604 Percentage of Consecutive Services.xls (http://www.cbrinfo.net/assets/cbr201604-percentage-of-consecutive-services.xls)

LCD L34219 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34219&ver=S&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=peripheral&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&)

CBR201604 Average Allowed Services per Beneficiary.xls (http://www.cbrinfo.net/assets/cbr201604-average-allowed-services-per-beneficiary.xls)

Documentation and Files - National Physician Fee Schedule and Relative Value Files

CBR201604 Statistical Debriefing (http://www.cbrinfo.net/cbr201604-statistical-debriefing.html)

LCD Retirement Clarification (https://med.noridianmedicare.com/web/jeb/policies/lcd/retired/retirement-clarification)