Stay Tuned for Webinar

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CBR201604: Non-invasive Vascular Studies

3:00 P.M. ET
April 13, 2016
CBR201604: Non-invasive Vascular Studies

April 13, 2016
3:00 P.M. ET
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 (MAC) or DME Medicare Administrative Contractors (DME MAC). 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.
Webinar Outline

1. Introduction
2. Coverage & Documentation Overview
3. Methods & Results
4. References & Resources
5. Q&A
6. Survey
Webinar Protocol

- All attendee lines are muted
- Submit questions via chat when prompted by speaker
- Submit questions during the Q&A session at the end of webinar
- Ask questions pertinent to webinar
- Contact MAC for specific claims questions
Webinar Objective

Upon completion of this webinar, you should be able to:

- Demonstrate a general understanding of CBR201604: Non-invasive Vascular Studies
- Comprehend the analytical methods used to develop the report
- Locate policy references and resources
Sample CBR

- Provided for each topic:
  http://www.cbrinfo.net/

Comparative Billing Report (CBR)
NPI 1111111111
Non-invasive Vascular Studies

Introduction
CBR201604 focuses on rendering providers of all specialties, including radiology, who submitted claims for non-invasive vascular studies using Current Procedural Terminology (CPT®) codes 93830, 93832, 93834, 93840, 93856, and 93858. The measures for this report include:
- Average charges per beneficiary for a one-year period
- Percentage of consecutive services billed within 24 hours of another service
CPT® codes, order, and descriptions included in this CBR and your utilization of these codes are shown in the table below.

Table 1: Summary of Your Utilization
October 1, 2014 - September 30, 2015

<table>
<thead>
<tr>
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<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>93830</td>
<td>Doppler flow of extremal arteries, complex/nontread</td>
<td>$17,300.72</td>
<td>1,637</td>
<td>211</td>
<td>1,403</td>
</tr>
<tr>
<td>93832</td>
<td>Doppler flow of extremal arteries, unilateral/nontread</td>
<td>$5,000.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93834</td>
<td>Doppler flow of lower extremal arteries, complete/nontread</td>
<td>$13,000.00</td>
<td>410</td>
<td>87</td>
<td>214</td>
</tr>
<tr>
<td>93836</td>
<td>Doppler flow of upper extremal arteries, unilateral/nontread</td>
<td>$5,000.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93840</td>
<td>Doppler flow of subclavian veins, complex/nontread</td>
<td>$9,900.00</td>
<td>410</td>
<td>87</td>
<td>214</td>
</tr>
<tr>
<td>93856</td>
<td>Doppler flow of extremal arteries, unilateral/nontread</td>
<td>$17,700.00</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$59,900.00</td>
<td>2,617</td>
<td>473</td>
<td>509</td>
</tr>
</tbody>
</table>

An investigation by the Office of Inspector General (OIG) found large variances in billing patterns for ultrasound services, with 28 high volume providers accounting for 68 percent of Part B expenditures for ultrasound in more than any other percent of Medicare beneficiaries receiving these services. In its July 2016 report titled, "Medical Part B Billing for Ultrasound," the OIG indicated that twice as many beneficiaries received ultrasound services in high volume areas compared to the rest of the country, and the rates of ultrasound services to beneficiaries in those areas were three times higher than the rest of the nation.

According to The Supplementary Appendix for the Medicare Fee-For-Service MD Improper Payments Report, the Compensable False Positive Rate (CFPR) indicates that 30 percent for the Radiology/Imaging category of the 139 (Radiography/ultrasonography, etc.) codes, which includes CPT® codes 93830, 93832, 93834, 93856, and 93858. One hundred percent of the cases were due to insufficient documentation. The projected improper payments for this category totaled more than $606 million. BEUUS category 106 (Radiography/ultrasonography excepted ultrasound), which includes CPT® codes 93830 and 93832, had an error rate of 27 percent with projected improper payments of greater than $460 million.
CBR Purpose

Designed to:

- Provide information to the provider community
- Compare billing practices among Medicare providers and their peer groups

Give providers an opportunity to:

- Check their records against data in CMS files
- Review Medicare guidelines to ensure compliance
CBR Focus

Metrics:

- Average Allowed Services per Beneficiary
- Percentage of Consecutive Services (billed within 24 hours of another service)
Demographics

- 3,900 individual providers of non-invasive vascular studies
- Medicare Fee-for-Service (FFS) claims data
- Billing patterns different from their peers
Webinar Materials

- References and Resources
- Webinar slides
- MP4 of webinar
- Webinar Handout
- Webinar Q&A Handout
# Acronyms

<table>
<thead>
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<th>Code</th>
<th>Description</th>
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</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>
Coverage & Documentation

Overview
Office of Inspector General (OIG)

- Medicare Part B Billing for Ultrasound, OEI 01-08-00100, July 2009

Comprehensive Error Rate Testing (CERT)

- BETOS I3F Echography/ultrasonography other: 16%
- BETOS I3D Echography/ultrasonography carotid arteries: 22%
“News”-worthy Fraud

- Tampa Bay doctor to pay $400,000 to settle Medicare fraud case, The Tampa Bay Times, January 2014

# Medical Review Focus Areas

<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>
# Code Descriptions

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93880</td>
<td>Duplex scan extracranial arteries; complete bilateral study</td>
</tr>
<tr>
<td>93882</td>
<td>Duplex scan extracranial arteries; unilateral or limited study</td>
</tr>
<tr>
<td>93925</td>
<td>Duplex scan lower extremity arteries or bypass grafts; complete bilateral study</td>
</tr>
<tr>
<td>93926</td>
<td>Duplex scan lower extremity arteries or bypass grafts; unilateral or limited study</td>
</tr>
<tr>
<td>93970</td>
<td>Duplex scan extremity veins including responses to compression etc.; complete bilateral study</td>
</tr>
<tr>
<td>93971</td>
<td>Duplex scan extremity veins including responses to compression etc.; unilateral or limited study</td>
</tr>
</tbody>
</table>
American College of Radiology (ACR):

“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.”
January 2015:
- 728 of 928 claims reduced or denied = 76%

February 2015:
- 437 of 588 claims reduced or denied = 74%

March 2015:
- 510 of 667 claims reduced or denied = 76%
Minimal documentation without specific location or description of signs/symptoms, severity

Documentation of provisional diagnosis instead of specific clinical indication, e.g., R/O DVT

Documentation of unilateral medical necessity indications accompanied by performance of bilateral study, e.g., swelling in limb
Failure to document prior non-invasive vascular study history; post-operative complications, follow up vascular study

Submission of *contradictory documentation*, (i.e., “history of bruit – yes, current bruit on physical examination – no”)

Submission of provider letter *without the accompanying required vascular studies* radiology report for the billed date of service
Other Denial Reasons

- Missing or illegible provider signature
- No response to request for documentation
- Documentation was submitted but not for the CPT® codes billed
- Incomplete/missing beneficiary information
- Rendering physician submitted on the claim form was not the physician who performed the services per the documentation
Indications 93880/93882

- Bruits
- Recent stroke
- Symptomatic carotid stenosis
- Carotid artery injury/neck trauma
- Suspected aneurysm/dissection
- Post carotid endarterectomy monitoring
- See LCDs for all covered indications
Limitations 93880/93882

- 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.

- When reporting syncope as an indication for this service, it is necessary to document that other more common causes of syncope have been ruled out.
Used in the detection of extremity arterial compromise

Measure severity and hemodynamic significance of atherosclerosis

Monitor grafts for occlusion/reocurrence of anastomotic or distal disease

See LCDs for all covered indications
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.

- Minor S/S = hair loss, shiny thin skin, absence of single pulse, relative coolness of foot, lack of toenail growth
- Continuous burning of the feet
- Monitoring unchanged symptomatology or non-invasive medical treatment
Indications 93970/93971

- Deep Vein Thrombosis (DVT)
  - S/S of DVT include edema, tenderness, inflammation and/or erythema
  - S/S of pulmonary embolism i.e., dyspnea, chest pain
  - Unexplained LE edema after major surgical procedure

- Chronic venous insufficiency
  - Primary VV, secondary VV, post-thrombotic syndrome, recurrent DVT

- Evaluation of pre-procedural venous conditions

- Evaluation of post-procedural venous conditions
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.

Rarely necessary for bilateral limb edema in the presence of signs/symptoms of CHF, exogenous obesity and/or arthritis.
Limitations All Codes

- 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 not reported.
- Studies in the absence of signs/symptoms (screenings) are non-covered by Medicare.
- Blanket referrals.
More Limitations

- The performance of simultaneous arterial and venous studies during the same encounter should be rare. Documentation should be available to support the medical necessity for both studies.

- Ankle/Brachial Indices (ABIs), as separate procedures, are not reimbursable by some MACs.

- **Some testing methods are not covered:**
  - Thermography, mechanical oscillometry
  - Inductance, capacitance, photoelectric plethysmography
  - Light reflection rheography
Methods & Results
Report Data

- Medicare Part B *Rendering* Providers
  - Exception: Diagnostic Radiology (30)

- By National Provider Identifier (NPI)

- CPT® codes
  - 93880, 93882, 93925, 93926, 93970, 93971
  - Global Billing (no modifier 26/TC)
  - Professional Component (modifier 26)
Peer Groups: Used for comparison with the individual providers

- **State**: Medicare providers in the provider’s state
- **National**: All Medicare providers in the nation
Data Source

- CMS Integrated Data Repository
- Extracted: January 19, 2016
- DOS: October 1, 2014 – September 30, 2015
## Table 1

### Table 1: Summary of Your Utilization
October 1, 2014 – September 30, 2015

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<tr>
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<tbody>
<tr>
<td>93880</td>
<td>Duplex scan of extracranial arteries, complete/bilateral</td>
<td>$117,336.72</td>
<td>1,637</td>
<td>311</td>
<td>1,623</td>
</tr>
<tr>
<td>93882</td>
<td>Duplex scan of extracranial arteries, unilateral/limited</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93925</td>
<td>Duplex scan of lower extremity arteries, complete/bilateral</td>
<td>$102,592.23</td>
<td>492</td>
<td>93</td>
<td>484</td>
</tr>
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<td>93926</td>
<td>Duplex scan of lower extremity arteries, unilateral/limited</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93970</td>
<td>Duplex scan of extremity veins, complete/bilateral</td>
<td>$65,060.58</td>
<td>352</td>
<td>67</td>
<td>350</td>
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<td>93971</td>
<td>Duplex scan of extremity veins, unilateral/limited</td>
<td>$137.30</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$285,126.83</strong></td>
<td><strong>2,482</strong></td>
<td><strong>472</strong></td>
<td><strong>2,090</strong></td>
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CPT® codes and descriptors are copyright 2014/2015 American Medical Association. All rights reserved.
Applicable FARS/DFARS apply.
Table 1

CPT® Code Summaries

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Comparison Outcomes

There are four possible outcomes:

1. Significantly Higher
2. Higher
3. Does Not Exceed
4. N/A
Average Allowed Services per Beneficiary

Calculated as follows:

\[
\left( \frac{\text{Total Allowed Services}}{\text{Total Number of Beneficiaries}} \right)
\]
### Table 2: Average Allowed Services per Beneficiary
**October 1, 2014 – September 30, 2015**

<table>
<thead>
<tr>
<th></th>
<th>Your Average Allowed Services per Beneficiary</th>
<th>Your State’s Average Allowed Services per Beneficiary</th>
<th>Comparison with Your State’s Average</th>
<th>National Average Allowed Services per Beneficiary</th>
<th>Comparison with the National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>1.19</td>
<td>1.22</td>
<td>Does Not Exceed</td>
<td>1.23</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

A t-test was used in this analysis, alpha = 0.05.
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**October 1, 2014 – September 30, 2015**

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Calculating Average Allowed Services per Beneficiary

Calculated as follows:

\[
\frac{\text{Total Allowed Services}}{\text{Total Number of Beneficiaries}} \approx 1.19
\]

\[
\left( \frac{2482}{2090} \right) \approx 1.19
\]
Percentage of Consecutive Services

- Consecutive Services are Services Billed within 24 hours of one another
- Calculated as follows:

\[
\left( \frac{\text{Total Number of Consecutive Services}}{\text{Total Number of Services}} \right) \times 100
\]
Table 3: Percentage of Consecutive Services  
October 1, 2014 – September 30, 2015

<table>
<thead>
<tr>
<th></th>
<th>Your Percentage of Consecutive Services</th>
<th>Your State’s Percentage of Consecutive Services</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Consecutive Services</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consecutive Services</td>
<td>19%</td>
<td>4%</td>
<td>Significantly Higher</td>
<td>11%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha = 0.05.
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<td><strong>472</strong></td>
<td><strong>2,090</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Calculating Percentage of Consecutive Services

Calculated as follows:

\[
\left( \frac{\text{Total Number of Consecutive Services}}{\text{Total Number of Services}} \right) \times 100
\]

\[
\left( \frac{472}{2482} \right) = 19\% 
\]
References & Resources
# LCDs & LCAs

## Medicare Administrative Contractor

<table>
<thead>
<tr>
<th>Medicare Administrative Contractor</th>
<th>Active 10/01/15 (ICD-10)</th>
<th>Retired 09/30/15 (ICD-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cahaba Government Benefit Administrators, LLC</td>
<td>L34267</td>
<td>L30040</td>
</tr>
<tr>
<td>CGS Administrators, LLC</td>
<td>L34045</td>
<td>L31841</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>L33667, L33693, L33695</td>
<td>L28829, L28936, L28937, A93925, A93965, A93880</td>
</tr>
<tr>
<td>National Government Services</td>
<td>L33627, A52859</td>
<td>L27355, A47394</td>
</tr>
<tr>
<td>Noridian Healthcare Solutions, LLC</td>
<td>L34219, L34221, L34229</td>
<td>L33477, L33478, L33479</td>
</tr>
<tr>
<td>Novitas Solutions, Inc.</td>
<td>L35397, L35451, A52992</td>
<td>L34711, L34714, A47800</td>
</tr>
<tr>
<td>Wisconsin Physicians Service Insurance Corp.</td>
<td>L35751, L35753, L35761, (associated billing and coding guidelines)</td>
<td>N/A</td>
</tr>
<tr>
<td>National Coverage Determination</td>
<td>220.11</td>
<td>N/A</td>
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</tbody>
</table>
Office of Inspector General (OIG)

http://www.cbrinfo.net/cbr201604-recommended-links.html

- Medicare Part B Billing For Ultrasound, OEI-01-00100, July 2009
- Integrity Agreement Between The Office of Inspector General of the Department of Health and Human Services and Ravi Sharma, M.D., December 2013
http://www.cbrinfo.net/cbr201604-recommended-links.html

- The Supplementary Appendices Medicare Fee-for-Service 2014 Improper Payments Report
- Berenson-Eggers Type of Service (BETOS) Codes
Medicare Manuals

http://www.cbrinfo.net/cbr201604-recommended-links.html

- Medicare Claims Processing Manual, Chapter 12, Physician/Non-physician Practitioners

- National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services,
  - Chapter I, Sections D & E – General Coding Policies
The Brooklyn District Attorney’s Office

- Twenty-three Defendants – Including Nine Doctors – Charged With Enterprise Corruption in Massive $7 Million Medicaid Fraud, March 31, 2013

Tampa Bay Times

- Tampa Bay Doctor to Pay $400,000 to settle Medicare Fraud Case, January 2014
American College of Radiology (ACR)
- Noninvasive Vascular Diagnostic Studies, ACR Radiology Coding Source, January-February 2007

American Medical Association (AMA) Manuals:
- CPT® 2014 Professional Edition
- CPT® 2015 Professional Edition
Additional Resources

http://www.cbrinfo.net/cbr201604-recommended-links.html

Medicare Administrative Contractors (MAC)

- National Government Services: Medical Review Focus Areas

Social Security Administration (SSA)

- Title XVIII of the Social Security Act: Section 1862 (a) (1) (A), Section 1862 (a) (7), Section 1833 (e)
CBR Website

http://www.cbrinfo.net

- About Us
- CBR Releases
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FAQs

General FAQs

CBR Specific FAQs

- CBR201604: Non-invasive Vascular Studies
Provider Self-audit

- Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly
- Self-audits allow providers and suppliers to identify coverage and coding errors
- Refer to the following CBR sections for assistance
  - Documentation and Billing
  - References
Monday–Friday: 9:00 a.m. to 5:00 p.m. ET

- Toll Free 1–800–771–4430
- Email: cbrsupport@eglobaltech.com
Contacting MACs

Providers should contact the Medicare Administrative Contractor (MAC) for assistance with:

- Claim Information
- Documentation Requirements
- Billing and Coding
NPPES

National Plan & Provider Enumeration System

- Source for mailing address used for the CBR
- Correct your mailing information at [https://nppes.cms.hhs.gov/NPPES](https://nppes.cms.hhs.gov/NPPES)
Questions & Answers
We make every effort to address all questions submitted during our webinars. However, we cannot provide responses related to coding issues or to specific claims/scenarios. Since your Medicare Administrative Contractor (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. The contact information for your MAC is located at [http://go.cms.gov/IMap](http://go.cms.gov/IMap).