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INTRODUCTION

Good afternoon everyone, and welcome to the Comparative Billing Report Webinar to discuss **CBR201406 Electrodiagnostic Testing**. 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 to produce and distribute CBRs. We are responsible for conducting the statistical analysis 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.

Today we are going to give you a general overview of the CBR, which is on the policy group related to electrodiagnostic testing, go over the coverage policy for these items, touch upon the methodology used to produce the report, go over additional resources available to you, and then we will be taking your questions at the end of the presentation.

During the Q&A session, we will enable a chat function which will allow you to submit questions relevant to today’s topic via your computers or devices. Please note that due to time constraints, we may be limited in the number of questions we will be able to answer this afternoon. However, those questions received at the time of registration or during our Q&A session that are relevant to today’s CBR topic, will be included in a formal Q&A document that will be posted to the CBR website within thirty days from today [http://www.cbrinfo.net/assets/cbr201406-webinar-questions-and-answers.pdf].

If you did not receive a CBR in the mail or via fax, you may download a copy of the Sample CBR by visiting [http://www.cbrinfo.net/](http://www.cbrinfo.net/). A sample CBR is produced for each CBR topic, and you may find it beneficial to have a copy of a CBR available to reference during the webinar.

The CBR is developed to provide education to the provider community by comparing a provider’s billing patterns to those of their peers. The goal of these reports is to provide a
tool that assists providers in their understanding of applicable Medicare billing rules while improving the level of care that they provide their Medicare patients.

Your receipt of a Comparative Billing Report is not a precursor to an audit, nor is there any assumption of wrong doing on your part. Instead, the CBR enables you to compare your billing practices with those of your peers.

This CBR focuses on providers of electrodiagnostic services and examines the following:

1. The average allowed charges per beneficiary
2. The average weighted services by category
3. And, the percentage of visits with nerve conduction study codes only

Approximately 5,000 provider NPIs were selected to receive a CBR for electrodiagnostic testing. These providers were selected by analysis of paid claims data that identified them as having different billing patterns when compared to their peers. This CBR applies to Medicare Part B providers that perform nerve conduction studies and needle electromyography on Medicare beneficiaries.

The methodology portion of this webinar will provide you with more information on the statistical analysis and NPI selection process.

And now Becke Turner will discuss the coverage and documentation for today’s topic as well as the references that you may refer to for further information.

**Coverage & Documentation**

Thank you Molly...and good afternoon everyone. My name is Becke Turner and I am a Project Manager and Registered Nurse with Palmetto GBA. Today, I will present an overview of the coverage and documentation guidelines that electrodiagnostic providers must follow in order for their claims to be paid by Medicare.

Please keep in mind we had three code categories: one for needle electromyography (EMG); one for nerve conduction studies (NCS); and another that combines these two where you have nerve conduction studies and the needle electromyography together (NCS & EMG).
Please pay special attention to the units of service (UOS). For example, if you look at CPT®/HCPCS Code 95907 the description reads as “Nerve transmission studies, 1–2 studies.” Therefore, the UOS you would report in this scenario would be one. So if you provided two studies, you would report one UOS. You would follow the same procedure if you performed five to six studies; you don’t report six studies if you did six studies, you would report one unit of service with the CPT®/HCPCS Code of 95909. So please keep in mind the UOS, and those will change as we go through additional groups of codes.

<table>
<thead>
<tr>
<th>CPT®/HCPCS Code</th>
<th>Abbreviated HCPCS Description</th>
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<tbody>
<tr>
<td>95905</td>
<td>Needle measurement and recording of movement and/or feeling</td>
</tr>
<tr>
<td>95907</td>
<td>Nerve transmission studies, 1–2 studies</td>
</tr>
<tr>
<td>95908</td>
<td>Nerve transmission studies, 3–4 studies</td>
</tr>
<tr>
<td>95909</td>
<td>Nerve transmission studies, 5–6 studies</td>
</tr>
<tr>
<td>95910</td>
<td>Nerve transmission studies, 7–8 studies</td>
</tr>
<tr>
<td>95911</td>
<td>Nerve transmission studies, 9–10 studies</td>
</tr>
<tr>
<td>95912</td>
<td>Nerve transmission studies, 11–12 studies</td>
</tr>
<tr>
<td>95913</td>
<td>Nerve transmission studies, 13 or more studies</td>
</tr>
</tbody>
</table>

If you look at the EMG codes [shown below], these are sometimes done per extremity. Therefore you can have a maximum of four for CPT®/HCPCS Code 95860. For CPT®/HCPCS Code 95861 however, where it says “two extremities with or without related paraspinal,” you would use a unit of service of one.

<table>
<thead>
<tr>
<th>CPT®/HCPCS Code</th>
<th>Short Description—Needle EMG</th>
<th>UOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>95860</td>
<td>Needle EMG; 1 extremity with or without related paraspinal</td>
<td>Max of 1</td>
</tr>
<tr>
<td>95861</td>
<td>Needle EMG; 2 extremities with or without related paraspinal</td>
<td>1</td>
</tr>
<tr>
<td>95863</td>
<td>Needle EMG; 3 extremities with or without related paraspinal</td>
<td>1</td>
</tr>
<tr>
<td>95864</td>
<td>Needle EMG; 4 extremities with or without related paraspinal</td>
<td>1</td>
</tr>
<tr>
<td>95865</td>
<td>Needle EMG; larynx</td>
<td>1</td>
</tr>
<tr>
<td>95866</td>
<td>Needle EMG; hemidiaphragm</td>
<td>1</td>
</tr>
<tr>
<td>95867</td>
<td>Needle EMG; cranial nerve supplied muscle(s) unilateral</td>
<td>1</td>
</tr>
<tr>
<td>95868</td>
<td>Needle EMG; cranial nerve supplied muscle(s) bilateral</td>
<td>1</td>
</tr>
<tr>
<td>95869</td>
<td>Needle EMG; thoracic paraspinal muscles (excluding T1 or T12)</td>
<td>1</td>
</tr>
<tr>
<td>95870</td>
<td>Needle EMG; limited study of muscles in one extremity</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Finally, when you look at CPT®/HCPCS Codes 95885, and 95886 for NCS & EMG combined, a unit of service maximum of four applies because they are per extremity. Only one unit of service applies to CPT®/HCPCS Code 95887.
The most important thing that you should take away today as it relates to provider responsibilities is that just because you receive payment does not always indicate correct coverage and coding. This only means that there were no edits up front to prevent you from making that error.

You are responsible for knowing what the Medicare coverage is for each of the services that you provide. You can look in two areas: the National Coverage Determinations (NCD) are released by CMS and the one NCD applies to everyone in the United States; each of you may also have a Local Coverage Determination (LCD) which you will need to check to see what the policies are for these services in your area. [You may search for either NCDs or LCDs by the document identification number at http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx.]

We reviewed all of the LCDs for NCS and EMG services in the United States and took some key components out of all of them. Every one of the LCDs refers to the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) [http://www.aanem.org/Home.aspx] which is considered the gold standard for the United States. Another thing you should keep in mind is to adhere to the 2014 Current Procedural Terminology (CPT) code descriptions [https://commerce.ama-assn.org/store/]. Finally, although local and state licensure requirements vary considerably, you are responsible for understanding, knowing, and being in compliance with the local and state licensure requirements in your area.

**Local Coverage Determinations**

Every state has policies discussing NCS and EMG as part of their Local Coverage Determinations. Some of them are active and some of them are scheduled for final in 2014. When we developed this CBR, we checked all of the LCDs and took the key points out of them.

When you get this CBR the big question is why is my utilization different? This does not mean that it is wrong; it just means that it is different. These are the questions that you should ask yourself:

<table>
<thead>
<tr>
<th>CPT®/HCPCS Code</th>
<th>Short Description—NCS and Needle EMG</th>
<th>UOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>95885</td>
<td>Needle electromyography, each extremity, with related paraspinal areas, where performed, done with NC</td>
<td>Max of 4</td>
</tr>
<tr>
<td>95886</td>
<td>Needle electromyography, each extremity, with related par., done with NC</td>
<td>Max of 4</td>
</tr>
<tr>
<td>95887</td>
<td>Needle electromyography, non-extremity (cranial nerve supply..., done with NC</td>
<td>1</td>
</tr>
</tbody>
</table>

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When you get this CBR the big question is why is my utilization different? This does not mean that it is wrong; it just means that it is different. These are the questions that you should ask yourself:
1. Is my service covered by Medicare? Look at the services that you bill for and make sure that they are covered by Medicare based on the LCD and NCD.

2. Do I possess the required credentials to perform these services for a Medicare beneficiary? You need to determine what jurisdiction corresponds with the state you are in and then refer to the LCD for that jurisdiction to make sure that you are in compliance.

3. Am I correctly coding my EMG and NCS services? Refer to you CPT code and make sure that the description is appropriate for the service that you provided.

4. Am I correctly calculating my units of service (UOS) for these services? A lot of mistakes are made when calculating units of service. You need to make sure that you are correctly calculating the UOS based on the CPT description.

Non-covered NCD Services is applicable to everyone attending this webinar. If you go to CMS [http://www.cms.gov/Medicare/Medicare.html] and enter the number 160.23 [in the search field] it should take you to the National Coverage Determination (NCD) for Sensory Nerve Conduction Threshold Tests (sNCT). This NCD stipulates that you must report the sNCT service with the G0255 code.

You should NOT report sNCT with codes 95905 through 95913. This is an example of how you should make sure that the service you provide is correctly described by the code assigned. If you are incorrectly paid for an sNCT service while using one of the codes from 95905 to 95913 then you could be at risk for an overpayment. You want to make sure that you are billing the right service with the right code.

You should not bill screening tests for polyneuropathy (95905–95913) when patients are diagnosed with diabetes or end stage renal disease (ESRD). Medicare will not pay for these screening services.

Fixed anatomic templates and portable hand-held devices are not covered separately. If you are providing that kind of service, it is included in an evaluation and management (E&M) service and you should not report and bill is separately with the codes 95905–95913.

Neurological evaluation includes the physical exam NCS performed in conjunction with an EMG. NCS alone is considered screening and screening is not covered with only one exception for carpal tunnel syndrome. A diagnosis on carpal tunnel syndrome may be billed with a 95905 code with two units of service.

You need to check with your state and local licensing agencies for your scope of practice. Electrodiagnostic exams with NCS and EMG require special train-
These are typically included in neurology, and physical medicine and rehabilitation. However, there are some deviations from this sometimes for a fellowship or other training. These deviations were not included in our data analyzed. In some states physical therapy is included in the scope of practice and can be done. This is an example of when you would need to go to your local and state medical licensing boards within your state to find out what the licensing requirements are and then go to your LCD to see what the specific requirements are for your particular location.

Make certain that the code you have used matches the service provided. These particular situations may cause errors if coded incorrectly:

- If NCS are not performed on a particular day then you should use 95860–95864 and 95867–95870.
- If you are performing NCS and the EMG on the same day then 95885, 95886, and 95887 should be utilized.
- 95870 and 95885 should be used when 4 or fewer muscles are tested. You would not use four units of service with these codes. Those four muscles tested would be considered one unit of service.
- If five or more muscles have been tested then you should choose the appropriate code from 95860 through 95864. Again, this would be one unit of service that included five or more muscles.

It is quite common for people to make mistakes when assigning the units of service. You need to make sure that your billing staff understands how the units of service are assigned to avoid this type of error. You can report 95905 once per upper extremity therefore the maximum you would ever see is two. Only one unit of service can be reported for 95908 through 95913. Codes 95860 through 95865 also can only be reported with one unit of service. Codes 95885 or 95886 are once per extremity therefore there is a maximum of four that can be reported for units of service.

**REFERENCES**

The following references have been listed for your convenience:

- American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) [www.aanem.org]
- Practice Parameter For Electrodiagnostic Studies in Carpal Tunnel Syndrome: Summary Statement [https://www.aanem.org/getmedia/7ddc9ef9-e91-4b48-9c1a-53454313001e/CTS.pdf.aspx]
• **Practice Parameter for Needle Electromyographic Evaluation of Patients with Suspected Cervical Radiculopathy: Summary Statement** [http://www.aanem.org/getmedia/23b78e7c-f4f4-46bb-84e1-0cea7617a699/cervicalRadiculopathy.pdf.aspx]


• **Usefulness of Electrodiagnostic Techniques in the Evaluation of Suspected Tarsal Tunnel Syndrome: An Evidence-Based Review** [http://www.aanem.org/getmedia/51417557-424c-4c29-be6a-5bbaff64517c/TarsalTunnel.pdf.aspx]


• **Recommended Policy for Electrodiagnostic Medicine, Position Statement** [http://www.aanem.org/getmedia/4eb449e2-c705-45b7-a5df-7cf024bb4b74/2014-Recommended_Policy_EDX_Medicine_.pdf.aspx]

**Policy References**

Here are the policy references for individual states. You need to: (1) find the jurisdiction for your area [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/]; (2) locate the LCD number in the table below; and then (3) enter that LCD number in the Document ID search field at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx].

<table>
<thead>
<tr>
<th>MAC Contractor</th>
<th>LCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGS Administrators, LLC</td>
<td>L33249</td>
</tr>
<tr>
<td>Cahaba Government Benefit Administrators, LLC</td>
<td>L33068</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>L34480</td>
</tr>
<tr>
<td>National Government Services, Inc.</td>
<td>L33386</td>
</tr>
<tr>
<td>Noridian Healthcare Solutions, LLC</td>
<td>L33476</td>
</tr>
<tr>
<td>Novitas Solutions, Inc.</td>
<td>L29547, L32723</td>
</tr>
<tr>
<td>Palmetto GBA, LLC</td>
<td>L34606</td>
</tr>
<tr>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>L31346 Billing &amp; Coding Guidelines 040113</td>
</tr>
</tbody>
</table>
Keep in mind that some of these jurisdictions have future LCDs that will include some of these points that have been discussed today. Look at the draft/future LCD to find out what is going to change in your state so that you can be prepared for these policies.

The CMS Internet-only manuals [http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html] provide more detailed guidance on topics related to this CBR:


At the website for the Office of Inspector General (OIG), [http://oig.hhs.gov](http://oig.hhs.gov) you may find Questionable Billing for Medicare Electrodiagnostic Tests, April 2014, OEI–04–12–00420 [http://oig.hhs.gov/oei/reports/oei-04-12-00420.pdf]. Electrodiagnostic tests have been a long standing issue with the OIG. There are probably many reports out there; the OIG link is one that you should have as a favorite to keep up with ongoing investigations.

**Methodology & Results**

Good afternoon, my name is Cheryl Bolchoz and I am a Statistical Analyst with Palmetto GBA. I will be guiding you through the Methodology and Results sections.

An individualized report was sent to about 5,000 Medicare Part B providers identified by the NPI submitted on the claim as the “rendering NPI”. Each report contains the provider’s billing history and patterns and compares them to his peers. These comparisons are given so that each provider is aware of where he stands and if his billing practices are different than his peers.

Each provider is compared to two peer groups:

- The **Specialty** peer group which is defined as all Part B Medicare providers with allowed charges for electrodiagnostic tests in the provider’s specialty as submitted on the claim. If a Provider billed under more than one specialty, the provider specialty was determined by the specialty with the greatest proportion of allowed charges.
The **National** peer group which is defined as all Part B Medicare providers in the nation with allowed charges for electrodiagnostic testing.

Analysis was based on the latest version of claims as of June 4, 2014 extracted from the CMS Integrated Data Repository and loaded into Palmetto GBA’s Statistical Analysis Data Warehouse. This report includes claims with dates of service between January 1, 2013 and December 31, 2013.

Table 1 [of the CBR that you received or of the Sample CBR available at http://www.cbrinfo.net/cbr201406-sample-cbr.html] serves as a listing of the CPT®/HCPCS categories, codes, and descriptions used in the CBR, as well as a summary of the utilization for each code. The table lists the number of distinct beneficiaries billed for each code, the total allowed services, and the total allowed charges for each code for the NPI listed at the top of the page. The total row provides the number of distinct beneficiaries for all codes and the total allowed services and charges for this NPI. The sum of the beneficiary counts by CPT®/HCPCS code may not equal the total beneficiary count because there could be beneficiaries that were billed with multiple CPT®/HCPCS codes during this time period.

There are 4 possible outcomes for the comparisons between the provider and the peer groups:

1. **Significantly Higher** is displayed if the provider’s value is higher than the value of the peer group and the statistical test used confirms that it is significantly higher.
2. **Higher** is displayed if the provider’s value is higher than the value of the peer group, but the statistical test does not confirm the significance.
3. **Does Not Exceed** is displayed if the provider’s value is not higher than the value of the peer group.
4. **N/A** is displayed if the provider did not have any allowed charges in the category of analysis.

Average allowed charges per beneficiary is calculated as the “Total Allowed Charges” divided by the “Total Number of Beneficiaries.” This analysis aggregates all 3 categories (NCS, EMG, and combined NCS & EMG) to find the average total amount per beneficiary.

Table 2 [of the CBR that you received or of the Sample CBR available at]
http://www.cbrinfo.net/cbr201406-sample-cbr.html] is an example of the analysis of the Average Allowed Charges per beneficiary.

If we look at this example, we find that this provider’s average allowed charges per beneficiary for all electrodiagnostic tests was $295.05, while his specialty’s average allowed charges per beneficiary was $292.88 and the national average was $301.25. Although the provider’s average did exceed his specialty’s average, the result was not significant according to the results of the t-test so “Higher” was marked under “Comparison with your Specialty’s Average.” In addition the provider’s average did not exceed the national average and therefore “Does Not Exceed” was marked under the column “Comparison with the National Average.”

The Average Weighted Services per beneficiary by category is calculated as the “Total Weighted Services by Category” divided by the “Total Number of Beneficiaries in the Category.” The Average Weighted Services per beneficiary is calculated separately for each of the 3 Categories. Weights of each service are determined by the specific CPT®/HCPCS code. I will give you an example of how weights are calculated on the next two slides.

The weighted services calculation is only applied to the NCS codes 95907–95913 where the CPT®/HCPCS code represents multiple studies. My example will be applied to CPT®/HCPCS code 95909, where the CPT®/HCPCS code represents 5–6 studies. Take the minimum, in this case it is 5 studies. Then multiply by the number of allowed services on the claim line for this CPT®/HCPCS code. If a provider has 1 allowed service for this code, then the weighted services would be 1 x 5, or 5. If, however, a provider billed for multiple services for this code, for example, 2 services, then the weighted services would be 2 x 5, or 10.

Providers should only submit one service per visit for any of these CPT®/HCPCS codes; however, we did find circumstances where a provider billed and was paid for multiple services.

Table 3 [of the CBR that you received or of the Sample CBR available at http://www.cbrinfo.net/cbr201406-sample-cbr.html] is an example of the analysis of the “Average Weighted Services per Beneficiary.” Each row in the table corresponds to a different CPT®/HCPCS category. The first row of the table provides the average weighted services for per beneficiary for claim
lines in the NCS category. In this example, the provider’s average, listed under the column “Your weighted Average Services per Beneficiary” is 11.52. The average for his specialty is 8.45, and for the nation equals 8.72. Since the provider’s average is significantly higher than the average of his specialty and the nation, according to the results of the t-test, the outcome of “Significantly Higher” is listed for the comparison with the specialty and the nation.

The next 2 rows provide the comparison of the EMG and NCS & EMG categories. Please keep in mind that the weighted services for these last two categories are all multiplied by a weight of 1. This is because only the NCS codes represent multiple studies.

The percentage of NCS only visits was calculated because these are frequently defined as “Screening” visits. Medicare should not allow for screening visits. A “visit” is defined as all allowed services for a beneficiary on a single date of service. Visits with NCS CPT®/HCPCS codes only were defined, excluding beneficiaries with carpal tunnel syndrome diagnoses, which is the exception to the screening rule. The Percentage of NCS only visits is calculated as total number of visits with NCS codes only (excluding carpal tunnel syndrome) divided by the total number of visits, multiplied by 100.

Table 4 [of the CBR that you received or of the Sample CBR available at http://www.cbrinfo.net/cbr201406-sample-cbr.html] is an example of the percentage of NCS only visits analysis. In this example, the provider’s percentage of NCS only visits is 46%.

The specialty’s percentage was 10%, and the national percentage is 16%. Here, the provider’s percentage is “Significantly Higher” than both the specialty and the national average according to the results of the chi-square test.

This concludes the methodology and results sections. Now Molly will go over the resources.

**Resources**

Thank you, Cheryl. And now I will review the educational information and resources you may utilize to ensure that you are meeting Medicare guidelines for electrodiagnostic testing.
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/]. The website includes a great deal of valuable 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
- CBR dissemination information
- Recommended Links
- Frequently Asked Questions
- Contact information for our Help Desk

Our website has two distinct FAQ sections. The first [http://www.cbrinfo.net/faqs.html] answers general CBR 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 CBR201406 Electrodiagnostic Testing FAQ page [http://www.cbrinfo.net/cbr201406-faqs.html], you will find questions and answers specific to this CBR, such as “How are the peers groups defined?” and “How was the data obtained for this report?”

Also, the Medicare Learning Network® [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/] provides access to CMS Program information 24 hours a day. It is the home for education, information, and resources for the healthcare professional community. The Medicare Learning Network® provides access to CMS Educational Products that include podcasts, articles and factsheets.

The following CMS resources are pertinent to this CBR and may assist you with developing policies to address any areas of concern. Please note that we provide links to all of the resources referenced in this webinar on our website [http://www.cbrinfo.net/cbr201406-recommended-links.html].

- The first document listed here [Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FraudA_Physicians_FactSheet_905645.pdf], ICN 905645, assists physicians in understanding how to comply with Federal laws by identifying “red flags” that could lead to potential liability in law enforcement and administrative actions.
ICN 006827, is a fact sheet gives providers some tools to prevent, detect, and report Medicare fraud and abuse.

The Department of Justice [http://www.justice.gov/publications/publicationsa.html] also includes resources that are applicable to this CBR:

- Diagnostic Imaging Group to Pay $15.5 Million for Allegedly Submitting False Claims to Federal and State Health Care Programs [http://www.justice.gov/opa/pr/2014/February/14-civ-200.html]

Lastly, the U.S. Department of Health and Human Services is another great resource for you to reference. They also issue reports that are pertinent to this CBR. The press release that was published in February 2014 titled Department of Justice and Health and Human Services Announce Record-breaking Recoveries Resulting From Joint Efforts to Combat Health Care Fraud [http://www.hhs.gov/news/press/2014pres/02/20140226a.html] is one such resource.

**Next Steps**

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.

Listed on this slide are some steps that you can follow when conducting a self-audit:

- Compare the CPT®/HCPCS code descriptions listed in the CBR to the services that you provided
- Confirm that the unit of service reported is accurate
- Review the jurisdiction-specific criteria as well as the licensing requirements in your state
- Contact the MAC, in your jurisdiction for answers to specific questions or concerns that you may have
Confirm your compliance and if errors are discovered, correct them
Educate your staff on the findings of the audit

**CONTACT INFORMATION**

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 for your convenience.

Providers should contact the Medicare Administrative Contractor, or MAC, for their geographic area for assistance with questions about a specific claim, documentation requirements and billing and coding questions. We encourage you to check with your MAC [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/] to ensure that you are meeting the standards for all services that you are providing.

eGlobalTech receives all contact information used in producing and disseminating the CBRs from the information providers and suppliers add to the Provider Enrollment, Chain, and Ownership System, or PECOS [https://pecos.cms.hhs.gov/]. PECOS is the internet-based Medicare provider enrollment system. The mailing address and fax number listed with each report is the one on file in the PECOS system. If your CBR lists an incorrect address or was sent to an incorrect fax number, you are advised to update this information in PECOS. This link is provided here, but we also have a link on the CBR website.

**Q&A**

And now we will be moving on to the Question and Answer portion of the Webinar. As I previously mentioned, you will be able to submit questions relevant to today’s topic via the chat function that we will enable. All questions pertinent to today’s topic will be included in a detailed Q&A document that may be downloaded from the CBR website within the next thirty days [http://www.cbrinfo.net/assets/cbr201406-webinar-questions-and-answers.pdf]. Additionally, an MP4 file that includes both the slide deck and audio from the webinar will be available within five business days [http://www.cbrinfo.net/cbr201406-webinar.html].

Debra, we are now ready to move onto the Q&A session. Thank you all for your time.