



August 30, 2019

RELI Group  
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Catonsville, MD 21228

CBR #: CBR201909  
Venipuncture

Organization Name 1  
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Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

**What is a CBR?** A CBR is an educational tool that reflects your billing patterns as compared to your peers' patterns for the same services in your state and/or nationwide. The CBR is intended to enhance accurate billing practices and support providers' internal compliance activities.

**Why did I get a CBR?** We are providing this report because your Medicare billing patterns differ from your peers' patterns within your state and/or specialty, and across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. **As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.**

Attend our free webinar on Sep. 5 at 3 p.m. ET. Please [register](#) prior to the event. If you are unable to attend the live event, visit [CBR.CBRPEPPER.org](http://CBR.CBRPEPPER.org) to access the recording and additional resources. Questions may be submitted at any time through the website Help Desk (Help/Contact Us tab) or at 1-800-771-4430 (M – F, 9 a.m. – 5 p.m. ET).

**REMINDER:** Please ensure your email address and fax number are updated in the following systems:

[National Plan and Provider Enumeration System](#) (NPPES)  
[Provider Enrollment, Chain, and Ownership System](#) (PECOS)

Sincerely,

The CBR Team

**Comparative Billing Report (CBR) 201909**  
**August 30, 2019**  
**Venipuncture**

### **Introduction**

CBR201909 focuses on rendering providers who billed Current Procedural Terminology (CPT®) code 36415 for which a Medicare Part B claim was submitted and paid. Specifically, this CBR focuses on providers who submitted CPT® visits with more than one CPT® code.

According to the *2018 Comprehensive Error Rate Testing (CERT)* report, laboratory tests had an improper payment amount of \$392,674,133 in 2018. Additionally, routine venipuncture procedures, submitted with CPT® code 36415, accounted for 12.9 percent of laboratory testing errors, and 15.8 percent of claim lines with venipuncture procedures contained errors.

The criteria for receiving a CBR is that the provider had at least 423 total visits with more than one CPT® code 36415 billed during the encounter.

### **Coverage and Documentation Overview**

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. The information provided does not supersede or alter the coverage and documentation policies outlined by the Medicare Administrative Contractors' (MACs') Local Coverage Determinations (LCDs).

For the purposes of this CBR, laboratory testing services, including venipuncture procedures, were reviewed. The CPT® codes for these services are 36415, 80047-80081, 82009-84999, 85002-85999 and 89049-89240. The Medicare Part B claims submitted and paid for these services from rendering physicians were analyzed.

The National Correct Coding Initiative (NCCI) Manual provides guidance regarding submission of CPT® code 36415. The manual states in Chapter 5, “CPT® code 36415 describes collection of venous blood by venipuncture. Each unit of service (UOS) of this code includes all collections of venous blood by venipuncture during a single episode of care regardless of the number of times venipuncture is performed to collect venous blood specimens. Two or more collections of venous blood by venipuncture during the same episode of care are not reportable as additional UOS.”

### **Basic Coding Guidelines**

Table 1 identifies CPT® codes that may be reported for venipuncture and laboratory services.

**Table 1: CPT® Codes for Venipuncture and Laboratory Procedures**

<b>CPT® Code/Code Set</b>	<b>Descriptor</b>
36415	Collection of venous blood by venipuncture
80047-80081	Organ and disease multi-test laboratory panels
82009-84999	Chemistry laboratory procedures

CPT® Code/Code Set	Descriptor
85002-85999	Hematology laboratory procedures
89049-89240	Other pathology services and laboratory procedures

CPT® codes and descriptors are copyright 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

**Table 2: Summary of Your Utilization of CPT® Codes 36415, 80047-80081, 82009-84999, 85002-85999 and 89049-89240 between April 1, 2018 and March 31, 2019**

CPT® Code	Allowed Charges	Allowed Services	Beneficiary Count*
<b>36415</b>	\$6,369.00	2,123	928
<b>80047-80081</b>	0	0	0
<b>82009-84999</b>	\$11,435.38	1,338	329
<b>85002-85999</b>	\$3,542.46	378	281
<b>89049-89240</b>	0	0	0
<b>Total</b>	<b>\$21,346.84</b>	<b>3,839</b>	<b>1,538</b>

\*A beneficiary is counted once per row of CPT® code level. The total “Beneficiary Count” is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.

## Metrics

This report is an analysis of the following metrics:

1. Percent of visits with laboratory codes billed with CPT® code 36415
2. Percent of total allowed amount for routine venipuncture in conjunction with a laboratory code
3. Percent of visits billed with CPT® 36415 where multiple units of 36415 were billed

The CBR team identified the services for venipuncture and laboratory services submitted with CPT® codes 36415, 80047-80081, 82009-84999, 85002-85999 and 89049-89240. Statistics were calculated for each provider, all providers in the state and all providers in the nation:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider’s state or territory with allowed charges for the procedure codes included in this study
- The national peer group is defined as all rendering Medicare providers (excluding clinical laboratory specialty) in the nation with allowed charges for the procedure codes included in this study

Each provider’s values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state (state code) and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider’s value is above the 90<sup>th</sup> percentile from the state or national mean.
2. Higher — Provider’s value is greater than the state or national mean.
3. Does Not Exceed — Provider’s value is not higher than the state or national mean.
4. N/A — Provider does not have sufficient data for comparison.

## **Methods and Results**

This report is an analysis of rendering providers who submitted laboratory codes on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims on July 18, 2019. The analysis includes claims with dates of service from April 1, 2018, through March 31, 2019. For the trend analysis (Figure 1), claims represent dates of service between April 1, 2016, and March 31, 2019.

### **Metric 1: Percent of Visits with Laboratory Codes Billed with CPT® Code 36415**

Table 3 shows your percent of visits with laboratory codes billed with CPT® code 36415. This is calculated as follows:

- The total number of times one or more laboratory codes (80047-80081, 82009-84999, 85002-85999 and 89049-89240) is billed in conjunction with CPT® code 36415 is divided by the total number of times laboratory codes (80047-80081, 82009-84999, 85002-85999 and 89049-89240) billed with or without CPT® code 36415. The result is multiplied by 100:

$$\left( \frac{\text{Total visits with one or more laboratory codes billed with CPT® code 36415}}{\text{Total Number of Visits with Laboratory Codes Billed}} \right) \times 100$$

Your comparison in your state and in the nation is presented in Table 3.

**Table 3: Percent of Visits with Laboratory Codes Billed with CPT® Code 36415**

Total visits with 1+ laboratory codes billed with CPT® code 36415	Total Number of Visits with Laboratory Codes Billed	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
1,092	1,100	99%	60%	Significantly Higher	62%	Higher

### **Metric 2: Percent of Total Allowed Amount for Routine Venipuncture in Conjunction with a Laboratory Code:**

Table 4 shows the percent of total allowed amount for routine venipuncture in conjunction with a laboratory code. This is calculated as follows:

- The total allowed amount for CPT® 36415 when billed with one or more laboratory codes (80047-80081, 82009-84999, 85002-85999 and 89049-89240) is divided by the total allowed amount for laboratory code (80047-80081, 82009-84999, 85002-85999 and 89049-89240) with or without CPT® 36415. The result is multiplied by 100:

$$\left. \frac{\text{Total allowed amount for CPT® 36415 and laboratory codes when billed together}}{\text{Total allowed amount for laboratory codes with or without CPT® code 36415}} \right) \times 100$$

Your comparison in your state and in the nation is presented in Table 4.

**Table 4: Percent of Total Allowed Amount for Routine Venipuncture in Conjunction with a Laboratory Code**

Total allowed amount for CPT® 36415 and laboratory codes when billed together	Total allowed amount for laboratory codes with or without CPT® code 36415	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
\$18,200.86	\$18,253.84	99.7%	67%	Significantly Higher	68%	Higher

**Metric 3: Percent of Visits Billed with CPT® 36415 where Multiple Units of CPT® 36415 were Billed**

Table 5 shows the percent of visits billed with CPT® code 36415 where multiple units (two or more) were billed. This is calculated as follows:

- The total number of visits where more than one CPT® code 36415 was billed per beneficiary per date of service is divided by the total number of visits billed with CPT® 36415.

$$\left. \frac{\text{Total number of visits where 2+ CPT® code 36415 are billed per beneficiary per date of service}}{\text{Total number of visits for CPT® 36415}} \right) \times 100$$

Your comparison in your state and in the nation is presented in Table 5.

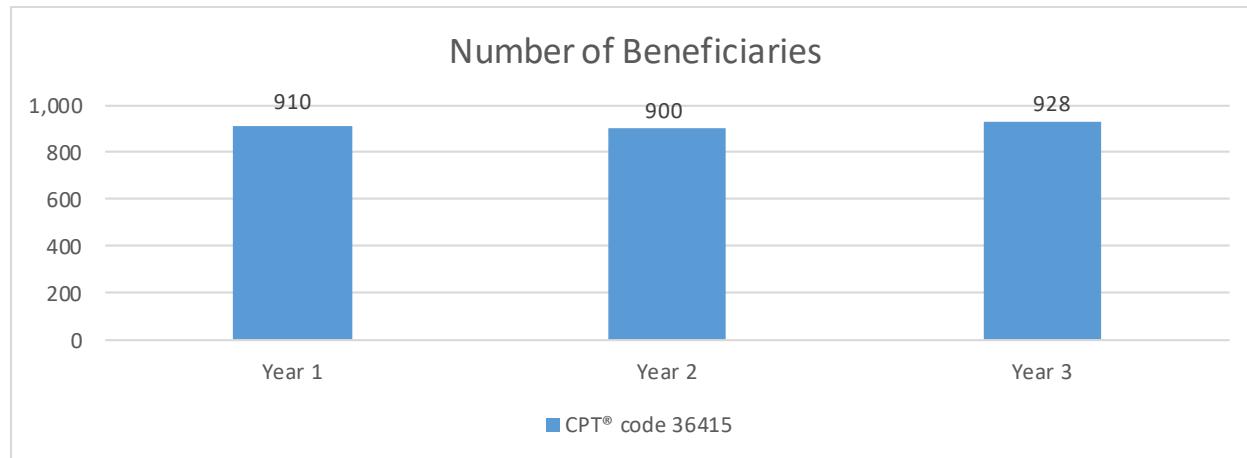
**Table 5: Your Percent Visits Billed with CPT® 36415 Where Multiple Units of CPT® 36415 Were Billed**

Total number of visits where 2+ CPT® code 36415 are billed per visit	Total number of visits billed with CPT® 36415	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
1,093	2,122	51.5%	58%	Does not Exceed	62%	Does not Exceed

Figure 1 illustrates the trend over time for the analysis of the number of beneficiaries for CPT® code 36415:

- Year 1: April 1, 2016 – March 31, 2017
- Year 2: April 1, 2017 – March 31, 2018
- Year 3: April 1, 2018 – March 31, 2019

**Figure 1: Trend Over Time Analysis of Number of Beneficiaries for CPT® Code 36415**



## **References and Resources**

*CPT® 2017 Professional Edition*

[2018 Medicare Fee-for-Service Supplemental Improper Payment Data](#)