CBR201909: Venipuncture
Webinar Questions and Answers

September 5, 2019

Q: What is a CBR?

A: A CBR is a Comparative Billing Report, and it is created to compare providers' billing statistics to those of their peers on a state or specialty level and a nationwide level.

Q: Within an organization, who receives the CBR?

A: Each CBR contains specific guidelines as to how a provider is included in the CBR analysis. If a provider meets the criteria to receive a CBR, a notice is sent to the email address filed in the Provider Enrollment, Chain, and Ownership System (PECOS) and National Plan and Provider Enumeration System (NPPES) system. The notice informs the provider that a CBR is available and includes information for obtaining the CBR.

Q: Is there a way to receive a list of providers who received CBRs within a group practice or receive information for a large group of providers?

A: The providers who receive a CBR will receive individual notifications via the email address or fax number listed in PECOS. If there is a question as to whether or not all notifications were received for a group of providers, our Help Desk can assist with lists of National Provider Identifier (NPI) numbers.

Q: How can I receive emails in regard to the CBR reporting?

A: A link to join our email list can be found on our home page: https://cbr.cbrpepper.org/home.

Q: Where would a CBR be sent if our provider was identified as an outlier? How can I change the contact information regarding where the CBR is sent?

A: If a provider is eligible to receive a CBR using the metrics explained in the webinar, an email is sent to the email address available in the NPPES database. If a valid email address is not available, the notice is sent via fax to the fax number in the NPPES database. Providers that do not have a valid email address or fax number in NPPES received their notification in hard-copy through the mail. Please ensure your email address and fax number are updated in the NPPES and the PECOS. The CBRs are not sent out; rather, they are available in the secure CBR Portal at

cbrfile.cbrpepper.org by using the unique validation code included in the email, fax, or mail notification.

Q: Where can I obtain the validation code to obtain my CBR report?

A: The validation code is sent upon distribution of the CBR to the provider by email, fax, or regular mail.

Q: I would like to view this webinar again; how can I find the recording, slides, and handout for the webinar?

A: The webinar slides, handout, recording, and transcript are posted on the CBR homepage: https://cbr.cbrpepper.org.

Q: Is the provider who qualified for a CBR the only individual who can obtain the CBR and data?

A: The CBR and validation code information is sent to the contact data listed in the NPPES system. Those who can access the email, fax receipts, or mail will therefore be in a position to view the CBR access information.

Q: We did not receive a CBR. Can we request a CBR be sent for our providers or find a CBR on the website, even if the providers do not meet all the listed qualifications?

A: CBR reports are produced only if a provider meets the criteria for receiving a CBR, and the reports are not produced for providers upon request.

Q: Is it possible for us to receive a detailed list of the patients and dates of service that were included in the analysis for this CBR?

A: Due to volume of claims information, patient lists and detailed lists of the claims that were used in the analysis are not available from RELI Group, Inc.

Q: What does the term "allowed amount" represent?

A: The "allowed amount" refers to the allowed dollar amount that is assigned to each CPT code in the Medicare Fee Schedule. Due to the variance in billed amounts submitted by providers, use of the allowed amount creates a dollar amount that is comparable for all providers.

Q: Metric 2 involves allowed amounts for venipuncture and laboratory codes. How can you make a comparison when these allowed amounts vary according to laboratory test type?

A: The metric calculations were performed using a total allowed amount for all laboratory tests. The comparison is not specific to the type of test performed.

Q: Does the Medicare Fee-for-Service program provide guidance regarding the submission and payment of venipuncture codes?

A: The program provides direction within Section 1833(h)(3): "In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017) or under section 1834A (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section[99], the Secretary shall provide for and establish"

> "(A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter…"

Q: Is the payment for a venipuncture procedure included in the payment for a laboratory code?

A: Chapter 16, Section 60.1.4 of the Medicare Claims Processing Manual states that "specimen collection in each of the above circumstances is included in the laboratory fee schedule." This means that venipuncture is paid from the Clinical Laboratory Fee Schedule, but it is not included in the reimbursement rate for the specific laboratory test.

Q: Is it appropriate to submit more than one venipuncture code for one clinical encounter?

A: Multiple billings of code 36415 in the same encounter is not appropriate.